

EXAMINING CMS'S EFFORTS TO FIGHT MEDICAID FRAUD AND OVERPAYMENTS

HEARING

BEFORE THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
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EXAMINING CMS'S EFFORTS TO FIGHT MEDICAID FRAUD AND OVERPAYMENTS

TUESDAY, AUGUST 21, 2018

U.S. SENATE,
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:02 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Ron Johnson, Chairman of the Committee, presiding.

Present: Senators Johnson, Hoeven, Daines, McCaskill, Carper, Heitkamp, Peters, Hassan, Harris, and Jones.

OPENING STATEMENT OF CHAIRMAN JOHNSON

Chairman JOHNSON. Good morning. This hearing will come to order.

I want to thank Administrator Verma and General Dodaro.

Well, we certainly appreciate you coming before us. This is a follow up hearing to our June 27th hearing, where we really explored the Government Accountability Office (GAO) report on overpayments, primarily Medicaid, \$37 billion, and we have the Administrator here talking about some program initiatives she announced in June. So we will have you testify, and then we will have the General comment on how we can make these programs kind of long-lasting.

I would ask consent that my written statement be entered in the record,¹ and I have a couple of charts that is in front of everybody.

Do the witnesses have the charts as well? It would be nice if they did.

But just three charts kind of laying out the macro program in terms of health care spending,² and this is a modification of a chart I have shown repeatedly that really lays out the—I know this is a little more complex chart than I normally like putting up, but it tells a pretty good story.

The top line, the green line, is just an inversion of a chart that shows what percent of health care spending is paid directly by the patient. The fact that we have gone from about 21 percent in 1940 to 89 percent paid by other people—in other words, less than 11 percent now is paid directly by the patient. We have taken out the discipline of the free-market system, and I think that is one of the reasons you see the increase in health care cost.

¹ The prepared statement of Senator Johnson appears in the Appendix on page 47.

² The chart referenced by Senator Johnson appears in the Appendix on page 88.

But there is a very interesting series of articles in the Wall Street Journal. They describe the American health care system in 12 graphs. The most recent one was written by Joseph Walker, and his chart really starts in 1970, and he just shows the percent of total health care expenditures as a percent of gross domestic product (GDP). And when you put these things in similar scale, you see that they somewhat track.

But he points out he does it in 12 different time increments, starting in 1970, shortly after the initiation of Medicare and Medicaid, where back then, total health care spending was around 5 percent of GDP. So over the next couple of decades as Medicaid eligibility widened, you can just see the increased expenditures as a percent of GDP.

Come around 1993, 1999 was the rise of health maintenance organizations (HMOs), and you can actually see the curve flatten out there for about 6 or 7 years. But then for whatever reason—I cannot explain it, and by the way, this is not the be-all-end-all in terms of what causes. Obviously, within medicine, we can do a whole lot more things that obviously increases expenditures as well, but again, this is just one take on it.

You start seeing a rapid rise again right around the year 2000 when HMOs were starting to be moved away from by providers. Hospitals began to merge. Again, the decline of HMOs—and we also, in 2006, had the Medicare drug benefit, which happens in that same timeframe, where you see a pretty stark increase from somewhere of 12 percent of GDP to close to 17 percent, and then the recession hit. People did not have enough money. Again, people do not have a lot of money, so spending kind of leveled out. And then right around the implementation of Obamacare, you see the curve start to increase again.

But, again, I just thought that this was a pretty interesting graph.

OPENING STATEMENT BY SENATOR MCCASKILL¹

Senator McCASKILL. Does the third-party payment include insurance companies?

Chairman JOHNSON. Yes. This is insurance companies and government.

Senator McCASKILL. OK.

Chairman JOHNSON. So, again, the point there is when consumers separate from the—

Senator McCASKILL. So what you are saying is back when the people were paying directly and did not have insurance, they were paying 80 percent of the cost of their health care because they did not have insurance?

Chairman JOHNSON. Right.

Senator McCASKILL. And that now, they are not—they buy insurance instead?

Chairman JOHNSON. Again, what I am saying, direct payment for the product.

Senator McCASKILL. OK.

Chairman JOHNSON. OK.

¹ The prepared statement of Senator McCaskill appears in the Appendix on page 48.

Senator McCASKILL. But they are paying for insurance.

Chairman JOHNSON. Oh, but we pay for all this——

Senator McCASKILL. Yes. OK.

Chairman JOHNSON [continuing]. Through taxes, through insurance. OK. But, again——

Senator McCASKILL. It is getting a little confusing because third-party payment sounds like it is the government, and the vast——

Chairman JOHNSON. Right.

Senator McCASKILL. The majority of that is insurance companies, private insurance companies.

Chairman JOHNSON. Right, which is why I am——

Senator McCASKILL. Private free-market competitive insurance companies, correct?

Chairman JOHNSON. Right, well, again, this is accommodation of government and——

Senator McCASKILL. I just want to make sure we are being clear here that the third party is the “free market..”

Chairman JOHNSON. Understand. That is why I am explaining. The point I am making is when you separate the consumer of the product from the direct payment of the product.

We care deeply what our taxes are. We care deeply how much our insurance rates are, but when I go in to get a procedure, the provider does not even know what it costs. The accounting department does. The insurance guy knows. The Centers for Medicare and Medicaid Services (CMS) knows, but the rest of us are clueless.

Senator McCASKILL. Correct.

Chairman JOHNSON. And, again, the results, we have gone from 4 percent of GDP to about 17 or 18 percent, and it is just going to continue.

So I generally make the point if we can reconnect the consumer of the product to the payment of the product, bring free-market disciplines back into health care as much as possible, I personally think that would make a restraint.

Next chart.¹ And this is just, again, the macro level. We have seen this in our last hearing, the growth in Medicaid spending.

This chart shows in 2017, the Federal Government spent, according to the Congressional Budget Office (CBO), about \$430 billion. Total spending in 2017 is about \$600 billion. You project out another 10 years, CBO is estimating in 2027, the Federal Government will spend \$723 billion on Medicaid. Total spending will be somewhere in the \$1.1-\$1.2 trillion. So, again, it just shows why we need to control the cost of Medicaid so that the people who really do need it, that the funds are available.

And the final chart,² then, is just the subject of this hearing, to kind of bring this plane in for landing, the improper payments. You can see were about \$14.4 trillion before the implementation of Obamacare. Now it is \$37 billion. In my own mind, I think the fact that States are being reimbursed 100 percent from Medicaid expansion is certainly one of the causes of that when you take a look at the amount of ineligible payments being made. One State in par-

¹ The chart referenced by Senator Johnson appears in the Appendix on page 89.

² The chart referenced by Senator Johnson appears in the Appendix on page 90.

ticular, California, it just is screaming for greater controls, and that is really why we have the administrator here.

And, again, let me emphasize I really do appreciate the initiatives that you have announced. We need a little more meat on the bones there in terms of we need more audits, 50 State audits, but in general, whatever these initiatives are, whatever controls you put in place, I am hoping remain in place. That this is not just a 1 or 2-year program or a one-administration program. That we really do implement these things long term, provide the control, because we simply cannot afford to waste \$37 billion out of this program. There are people in need that really rely on this.

So, with that, I will turn it over to my Ranking Member, Senator McCaskill.

Senator McCASKILL. Thank you. Thank you, Mr. Chairman.

Thank you, Administrator Verma and Mr. Dodaro. Gene, thank you always for being here and all the good work. I know you are going to introduce your State auditors. You have told me you had State auditors in the house. So I will let you introduce them, but I am sending love to the State auditors. See, they have important work they can be doing here, and I am glad that we are going to cover that topic today. I think they are underutilized as being our partners in accountability for the Medicaid program.

Two months ago, we held a hearing to talk about the rate of improper payments in the Medicaid program. I have said it before, and I will say it again. This Committee has a responsibility to ensure that the Medicaid program, which provides vital health care to over 70 million Americans, regardless of preexisting conditions, spends taxpayer dollars appropriately and efficiently. This is true especially as managed care increasingly demands a greater proportion of Medicaid dollars.

In fact, both GAO and the Department of Health and Human Services (HHS) Office of Inspector General (OIG) published reports on continued weaknesses and program integrity risks and Medicaid managed care. Clearly, there is a need for greater transparency on how managed care organizations spend Federal dollars and greater program integrity and oversight in Medicaid in general.

Importantly, there is also a need to distinguish between improper payments and outright fraud. I think often, we are conflating those two terms, and when we throw out the figure \$37 billion and improper payments, I think the notion that is conjured up in most Americans' minds is "Oh my gosh, there are \$37 billion worth of frauds and cheats out there, and we are somehow giving them money."

That is not the case with improper payments. The reality is that fraud accounts for only a portion of the total improper payments, most of which result from provider screening and enrollment errors.

Many times, the improper payments, once they are pointed out, become proper payments because the error was just in the enrolling of the recipient and information surrounding that, not on whether or not they are actually entitled to the health care benefits they are receiving.

We have to address this problem and distinguish between beneficiary fraud and bureaucratic bungling. Those are two different

issues, and we should not use one to beat up the other because the recipients are not deserving of the title that somehow they are responsible for \$37 billion in improper spending.

Even as we discuss Federal efforts to prevent fraud in the Medicaid program, we have to talk about other factors that lead to negative health outcomes for Americans, particularly as we look at health care spending. There are so many other issues that are impacting the level of health care cost in this country besides the viability of the Medicaid program. The Medicaid program is not driving health care costs up. There are a number of different factors, including misplaced incentives and unbridled greed of the pharmaceutical industry.

First, we can fight back against skyrocketing prescription drug prices. Earlier this year, I released a report—and I hope you have read it, Administrator—that shows the average price of the 20 most popular brand-name Medicare Part D program drugs have risen 10 times the rate of inflation for 5 years running.

And last month, I released a second report showing that if the Federal Government could negotiate directly on prices for these drugs, like they do in every other country, except the good old United States of America where the American people are being asked to provide all the profits to these companies, the taxpayers could save up to \$2.8 billion a year.

Second, we can stop the over-prescription of opioids. For too long, opioid manufacturers have used illegal marketing and sales techniques to expand their market share and increase dependency on powerful and awfully deadly painkillers.

We need to do more to ensure the perpetrators of the opioid addiction crisis are held accountable. I would like us to revisit the Drug Enforcement Administration (DEAs) ability to hold the distributors accountable and stop the shipments that are outside the bounds of reasonable before they occur, so we are not sending thousands and thousands of pills to a community that is very small.

Finally, we need to keep the consumer protections built into the Affordable Care Act (ACA). In the latest attempt to strip millions of Americans of their health insurance, Republican Attorneys General (AG), including the Attorney General of my State, have gone to court to take away every single consumer protection in the law and the additional payments that seniors get on prescription drugs to fill the, “donut hole.”

This is decidedly not what the American people want. In fact, as of 2016, an estimated 27 percent of adults under the age of 65, 52 million Americans, had preexisting conditions that would make it difficult, if not impossible, to obtain affordable health care coverage if they did not have health insurance at work.

I can tell you that when I talk about this issue in the town halls of my State, even the reddest parts of my State where I am not very popular, every head nods. The notion that we are going to take away these consumer protections with nothing in place to secure protections is outrageous.

You and I agree, Mr. Chairman, on the need to lower costs in Federal health care programs, and you and I agree on transparency in pricing.

I have told the story in this hearing many times. I am a U.S. Senator. I had my knee replaced. Nobody could tell me what it cost. I did this myself personally calling my doctor, the hospital, the insurance company. I kept insisting on a number.

I finally got numbers from all three of them. Guess what? None of them agreed on what it cost. I can go within a quarter mile of my home in St. Louis and find the best cheeseburger, know how much it costs, know how big it is, see pictures of it, know how clean their bathrooms are, how good their service is, but I cannot go online and find out what is comparable apples-to-apples prices for a knee replacement and what the reviews are of each facility and each doctor and how much I am going to have to pay out of pocket. Why is that so hard? Why can we not bring pricing—the American people are really good shoppers. We cannot expect them to bring down the price of health care if they have no idea what that price is.

The silos of profit are working overtime in this building to keep us from busting these silos and letting the American people decide whether or not they are getting a good deal on their health care. I think that is some place that the Chairman and I have 100 percent agreement, and I would love to work on a bipartisan basis to see if we cannot bring transparency to pricing within our health care system.

Thank you, Mr. Chairman.

Chairman JOHNSON. So let me give a quick answer to your question. You asked why do we not know that? Because we are not paying for it. The consumers are not paying for it directly.

Where they are in the private sector, for example, Walmart, the State can look at, for example, a shoulder replacement.

Senator MCCASKILL. Well, I disagree with you.

Chairman JOHNSON. They are contracting with a particular provider, and they know exactly what that cost—and that is the private sector. But, again, they are the ones paying for it, and so they actually know.

Senator MCCASKILL. No, we are paying for it with higher insurance premiums.

Chairman JOHNSON. I know, but we are doing—when I say pay directly for it.

Senator MCCASKILL. Yes.

Chairman JOHNSON. We are paying indirectly through taxes and through insurance payments. Again, you do not have the price transparency forced on them by the marketplace.

Postscript to my thing. I meant to mention this. Medicaid—oh, by the way, the improper payments of Medicaid are a little bit different than other improper payments in other agencies because they are 99 percent-plus as all overpayment. They represent 26 percent of all government improper payments, even though Medicaid is about 9.6 percent of total Federal spending.

So, again, one of the reasons we are focusing on Medicaid is it is just so out of whack in terms of its representation.

And oh, by the way, Medicare Part D providers do negotiate with drug companies. So there is certainly drug—

Senator MCCASKILL. Not with the government.

Chairman JOHNSON. Yes. I mean, the providers do. The ones that you actually contract to buy your drugs from, they do negotiate prices. That is sometimes left out of the equation.

With all that being said, it is the tradition of this Committee to swear in witnesses. So if you will both stand—

Senator McCASKILL. We will quit debating and swear in the witnesses.

Chairman JOHNSON. That is kind of fun, isn't it?

Do you swear the testimony you will give before this Committee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. DODARO. I do.

Ms. VERMA. I do.

Chairman JOHNSON. Please be seated.

Now I got to find my script. Do we have introductions?

[No response.]

OK. We did not have real big introductions. So our first witness will be the Administrator of CMS, Seema Verma.

TESTIMONY OF HONORABLE SEEMA VERMA,¹ ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Ms. VERMA. Chairman Johnson, Ranking Member McCaskill, and Members of the Committee, thank you for the invitation to discuss CMS's efforts to increase accountability in the Medicaid program. I appreciate this Committee's recent work on this issue and share your commitment to improving program integrity in the Medicaid program.

Before coming to CMS, I spent most of my career working alongside States to help them reform and strengthen their Medicaid programs, whether it be seniors living in the community through the support of personal care services or the respite care that allows a parent to keep their child with a disability living at home. I have seen firsthand the difference that the Medicaid program makes in people's lives.

I believe that Medicaid is more than a safety net. It is the lifeline, one that needs to be preserved and protected for those who truly need and qualify for it. For all of Medicaid's recipients, we work to provide for the best quality of life, quality of care, and access to care so that they may live healthier, more fulfilling, and more independent lives.

However, I believe that Medicaid should be stronger to ensure that no deserving Americans fall through the cracks. We must and we can serve them better. The status quo is not acceptable.

When the Federal Government established the Medicaid program, it was intended to be a partnership between the Federal and State governments to care for society's most vulnerable citizens, with both jointly contributing toward the cost. However, that relationship has changed over the years.

With Medicaid being an open-ended entitlement, the program has grown and grown, and States have spent more and more. In 1985, Medicaid spending consumed less than 10 percent of State

¹ The prepared statement of Ms. Verma appears in the Appendix on page 52.

budgets and totaled just over \$33 billion. In 2016, that number had grown to consume 29 percent of total State spending at a total cost of \$558 billion.

However, despite our growth in spending, more than one-third of doctors will not even see a Medicaid patient, and as the program has greatly expanded, it has led to longer waits for care and increased program integrity risks.

Our vision for Medicaid is to reset and restore the balance to the Federal-State relationship, while at the same time modernizing the program to deliver better outcomes for the people we serve. This vision for transforming the Medicaid program is centered on three principles: greater flexibility, stronger accountability, and enhanced program integrity.

So let us start with flexibility. Every State has different needs and challenges, and that is why Washington should not design a cookie-cutter Medicaid program. Instead, CMS has offered States unprecedented flexibility to design health programs that meet the needs of their residents. CMS has significantly reduced the time States have had to wait for approval of their State plan amendments and waivers, and at the request of many States, we have released new guidance on how to incentivize community engagement in order to improve health outcomes.

We are also equally committed to our second pillar, strengthening accountability. That is why this year, CMS released our first ever Medicaid Scorecard, which compiles health outcome metrics. This is the first effort to publicly report on States and Federal administrative performance. It is time to be transparent about what our investment in Medicaid is buying.

And that brings us to our third pillar, enhancing program integrity, the topic of today's hearing. In June, we announced a new Medicaid program integrity strategy that will bring CMS into a new era of enhancing the accountability of how we manage Federal taxpayer dollars in partnership with States.

First, CMS has launched new eligibility audits. The expansion of Medicaid under the Affordable Care Act provided an unprecedented level of financial support for newly eligible, able-bodied adults. This created an opportunity for States to shift cost to the Federal Government and requires us to ensure States are accurately determining eligibility. These new audits will include assessing the effects of Medicaid expansion and its enhanced Federal match rate on State eligibility policy.

Second, we are taking steps to strengthen our oversight of State financial claiming and managed care rate-setting. Through our strengthened oversight, CMS has already recovered billions from one managed care State. CMS will also audit States contracting with managed care organizations, and we will be closely reviewing financial reporting to ensure that rates are appropriate and that costs are not inappropriately shifted to taxpayers.

Third, we are working to optimize how we use State-provided claims and provider data in our program integrity efforts. For the first time, as of last month, every State, DC., and Puerto Rico are now submitting data on their programs to the transformed Medicaid Statistical Information System (T-MSIS). We are now shifting from simply collecting the data to using advanced analytics and

other innovative solutions to improve data and maximize the potential for program accountability and integrity purposes.

Moving forward, we must continue to bolster our existing efforts and optimize the use of data to drive better health outcomes and improve program integrity efforts. Medicaid is too vital a program to let fraud and inappropriate spending threaten its sustainability, but as long as the program remains an open-ended entitlement and there is a 90 percent match rate for the expansion population, States have an incentive to find new ways to draw down Federal dollars. CMS will need to continually adapt and adjust our oversight policies.

Ultimately, we need to work together to consider structural changes to the Medicaid program that would control spending and incentivize fiscal responsibility while maintaining high-quality care.

Thank you for the opportunity to testify before your Committee, and I look forward to answering your questions.

Thank you.

Chairman JOHNSON. Thank you, Administrator Verma.

Our next witness really does not need an introduction, the Comptroller General of the United States, the head of the Government Accountability Office, Mr. Gene Dodaro.

TESTIMONY OF HONORABLE EUGENE L. DODARO,¹ COMPTROLLER GENERAL OF THE UNITED STATES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Mr. DODARO. Thank you very much, Mr. Chairman, Ranking Member Senator McCaskill, and Members of the Committee. I am very pleased to be here today to talk about the Medicaid program, the risks that we have identified, the steps CMS is taking to address those risks, and additional actions we believe are necessary in order to ensure the integrity of the Medicaid program going forward.

There are three areas that I want to cover briefly in my opening remarks. First, are the demonstrations. Demonstrations allow CMS to give States flexibility to spend money that normally would not be covered under the Federal matching requirements. One-third of total Medicaid spending now is under demonstration projects, which have been approved in three-quarters of the States.

Our concern is that many of these demonstration projects were formed on questionable practices and are leading to more spending on Medicaid than would be normal under the original program constraints. Also, the evaluations are done as to whether or not the demonstrations are proving to lead to effective policy operations in the future have limitations.

CMS has taken some action in this area. I am very pleased that they are now limiting the amount of spending that could be accrued under these demonstrations and carried over to the next year. That one change alone has saved \$100 billion in Federal and State Medicaid money from 2016 to 2018, according to CMS's estimates.

¹ The prepared statement of Mr. Dodaro appears in the Appendix on page 66.

We think additional steps that CMS is planning to take will better ensure the budget neutrality of these demonstrations and we also believe that there needs to be more efforts made to make sure the evaluations are reasonable, timely, and lead to information that can help inform policy decisionmaking going forward. So I am pleased they are taking action, but more action is needed in this area.

Second, are supplemental payments. These are payments that are made over and above reimbursement of claims for Medicaid or encounters under the managed care portion. In fiscal year (FY) 16 these payments totaled \$48 billion. We have raised concerns in the past about the need for more accurate and complete reporting on States' funds used to meet their own match, and without this information, there is the possibility that the States could be shifting cost to the Federal Government without even CMS knowing about it.

In addition, these payments, particularly the non-disproportionate health care payments, are supposed to be made to ensure that they are economical and efficient, and we believe there needs to be better criteria for that and it needs to be well articulated going forward. And there also needs to be the proper focus and attention on supplemental payments.

I know CMS is coming up with guidance or planning some policy guidance to be issued next year, and we are hoping that this policy guidance will address the recommendations that we have made in these areas.

And the last area concerning supplemental payments that needs to be addressed is to make sure that the payments are clearly tied to Medicare spending as opposed to local sources of funding in these areas. What we have found in the past is that in some cases, the supplemental payments were given to local providers who provided a large share to help the State meet their match and not necessarily because they had the highest level of uncompensated care for Medicaid recipients. So this is important to clarify and ensure payment integrity.

The last area is the audits that need to be done. Ms. Verma mentioned audits they are planning to put in place. These are very important. I am glad they are resuming after a 4-year hiatus—the beneficiary eligibility determinations. The managed care is my big concern. Of the \$36 or \$37 billion in improper payments, most of that is in the fee-for-service (FFS) and beneficiary eligibility determination. Only \$500 million of that is in managed care. Managed care has grown over the years without a lot of good payment integrity and oversight processes in place. CMS is planning to start that, but I think State auditors are a tremendous, untapped resource.

Two State auditors with us today have volunteered on their own to come to this hearing. Beth Wood, the State Auditor of North Carolina is on my left; she is also the president of the State Auditors Association. Daryl Purpera, the State auditor from Louisiana is with her. He will be the next president taking over that association for State auditors.

But with Medicaid expenses expected to continue to rise rather dramatically—it is one of the fastest-growing programs in the Fed-

eral Government—we cannot afford to have the State auditors on the sidelines here. They need to get in the game. They need to have a substantive and ongoing role, and I think it will pay huge dividends.

Administrator Verma and our team have had conversations on this, and all our recommendations, I am pleased we are having a very constructive dialogue on these issues.

This afternoon, our team will have arranged a meeting between the State auditors and CMS to hopefully start a dialogue that will lead to a very good role for them.

So I am very pleased to be here today. To us, this is a very important program for the American people, and we need to do everything we can to ensure the integrity of it and its survival in the future.

Thank you very much, Mr. Chairman.

Chairman JOHNSON. Thank you, General Dodaro.

One thing I failed to mention, but I have another sheet here, the dais, and this is right out of the GAO testimony.¹ You were talking about State auditors. In neither one of your testimonies, you really talked about some of the State gimmicks. This is one, and this is pretty darn abusive. I am not naming the State here, but this is where the Federal Government has paid \$155 million to the pot, the State put \$122 million, for a total of \$277 million that was paid to a county health facility. The county health facility takes \$6 million and then paid back \$271 million back to the State.

Obviously, on paper, it looks like the State Government is actually providing a match, but in reality, the Federal Government is paying the \$155 million.

And there are other gimmicks, whether it is sales tax, whether it is loans to cities, that type of thing. I think that is probably a hearing in and of itself, but hopefully, maybe during questions and answers, somebody might raise this. If not, I will at kind of the tail end.

But with that, I appreciate the attempts of our Members, and out of respect for their time, I will defer my questioning, starting with Senator McCaskill.

Senator McCASKILL. Thank you, Mr. Chairman.

Let me start with a little bit on preexisting conditions.

Ms. Verma, you have worked with insurers in the health care industry for years. Does it surprise you that GAO's review of the data from insurers show that the aggregate application denial rate for the first quarter of 2010 was 19 percent; that is, 19 percent of the people who tried to get health insurance on the private market were denied because of preexisting conditions? Does that figure surprise you?

Ms. VERMA. I am aware of that data, yes.

Senator McCASKILL. OK.

I am assuming that there is nothing inherently in place if the lawsuit that the Administration is supporting and that my State Attorney General is supporting is successful, there is absolutely nothing that can be done that would change the market reverting to that, correct, unless the Congress took action?

¹ The portion of Mr. Dodaro's testimony referenced appears on page 84.

Ms. VERMA. So I cannot speak to a pending lawsuit, but what I will say is that I am deeply concerned about individuals with pre-existing conditions, and I think that we need to have protections in place for those individuals. And so as the Administrator of CMS, my job is to implement the law, and if the law changes in some way, I would work with Congress to make sure that we had protections in place for people with preexisting conditions.

Senator MCCASKILL. Well, there is no reason a lawsuit could not have exempted preexisting conditions. Did you weigh in with the Department of Justice (DOJ) and ask them to in their filings specifically say that they wanted severability so that preexisting condition protection would remain?

Ms. VERMA. I cannot speak to a pending lawsuit.

Senator MCCASKILL. If people cannot get affordable coverage due to denials because they—or rescissions—because they forgot to put “acne” on their application or some other clerical error, which was certainly the case pre-ACA, is there any system in place for a place those people can go and get insurance?

Ms. VERMA. I strongly support individuals that have preexisting conditions.

Senator MCCASKILL. I just want you to walk us down what happens if the Administration is successful in their lawsuit and if this Congress—and we cannot even get the Majority Leader to have a vote on bipartisan legislation that would strengthen the exchanges that we have a lot of Republicans supporting.

In fact, I think that one of the leadership in the Republican Party actually said in the press last week, “I do not know what we would do if the lawsuit was successful. We have no plan in place, legislatively, to pick up this problem.”

So what I am trying to get at here, if people do not have any place they can go and get insurance, what happens to their health care?

Ms. VERMA. I think it is very important that people that have preexisting conditions have the appropriate protections in place so that they can access the coverage that they need.

Senator MCCASKILL. But the point I am trying to make is they will not have prevention. They will not have maintenance. They will only have really emergency care. So, in other words, diseases progress to the point that hospitalization is necessary, and then, of course, we all pay, right?

Ms. VERMA. I agree with you that those individuals should have the appropriate protections in place, and if the law changes in any way, shape, or form around that, we would work with Congress to address that issue to make sure that they had the appropriate protections in place.

Senator MCCASKILL. Well, it would be great if we could do that here this month. It would be great if the Majority would allow us to vote on a provision that would make sure those protections were in place if the lawsuit was successful.

I certainly am willing to stay here weekends, 24/7, to make sure those protections stay in place. There does not seem to be any sense of urgency about the fact that this lawsuit is moving its way through the courts and could blow up, I mean, all of the rural protections, women paying more than men.

I love it when men say, “Well, I should not have to cover the cost of women having babies,” and I always like to point out, “You have something to do with it.” It is not fair that women should have to pay more because they are the ones bearing children.

The four largest insurance companies denied health insurance to more than a half a million people based solely on preexisting conditions based on information that was brought out in 2010, and that is one in seven applicants that were denied.

Let me get to improper payments and State auditors in the time I have left.

Mr. Dodaro, you talked about this in your opening statement. We talked about CMS’s auditing plan. In response to the Chairman’s suggestion to you of private auditors, you suggested that CMS should engage State auditors for these efforts instead. Would you make sure that we have on the record for the Committee and make sure that—and I am sure that Administrator Verma is aware of this—that State auditors are already required to do the single audit every year? State auditors are already accustomed to looking at Federal programs and the integrity of those Federal programs in their State. Could you explain why this would be a seamless transition to add to the single audit responsibilities—taking a look at managed care and Medicaid particularly?

Mr. DODARO. Yes. The State auditors can have very deep and longstanding knowledge of the State Medicaid programs. In most States—and Administrator Verma mentions this in her statement—if not the number one budget item in the State, it is number two, and in some States, it is almost 30 percent of the entire budget of the State. So it is a very important responsibility.

Under Federal law, the Single Audit Act, as you mentioned, and OMB circulars, the States are required to perform an audit every year of the Medicaid program along with other State programs—

Senator McCASKILL. Child support.

Mr. DODARO [continuing]. That receive Federal money. Yes.

Senator McCASKILL. There are all kinds of programs.

Mr. DODARO. The Temporary Assistance for Needy Families (TANF) program, for example.

Senator McCASKILL. I mean, frankly, our State’s budget—and most States’ budgets—is dominated by passthrough money from the Federal Government.

Mr. DODARO. Yes.

And in the OMB guidance on this, there is a circular that specifies what compliance issues need to be checked by the State auditors who are doing those audits.

Some of the States contract out those audits. Some do them themselves. So the OMB compliance supplement is one vehicle that CMS could use.

Also, the single audits are always intended to be the base. That is, you start there, and then you can add other audits that focus and do more in-depth work, which is what I think could be done in a managed care arena.

In this area, CMS is starting to do audits on some of their programs, but they are on a 3-year cycle where they are covering one third of the States each year. So they will not be finished with their cycle until 2020 or 2021, and if they use the State auditors,

they would have knowledgeable people to start with. They could cover all the States every year if they really wanted to.

I am not saying that there should not be a role for contract auditors too, but to me, the State auditors are an unused resource that could be very helpful.

Senator MCCASKILL. And by the way, they have a bigger megaphone in each of their States. Their results and findings are telegraphed in a very bold way to the policymakers in those States. So, as you are working with the States to encourage flexibility and waivers to allow them all to make their own decisions, this is such a sensible partnership. It makes so much sense, and it will save us a lot of money because I guarantee you, State auditors, having some experience contracting audits and some experience using auditors on my staff, I will tell you, you will save a boatload of money if you go through the State auditors as opposed to hiring private contractual independent auditors.

Thank you, Mr. Chairman.

Chairman JOHNSON. I do want to quickly point out the limitation of State auditors, though. They are probably not going to be where you have a State really trying to expand eligibility to get the 90 percent match on Medicaid expansion or in the case of these gimmicks. I do not think you are going to have State auditors blowing the whistle. You would need Federal oversight.

Senator MCCASKILL. That is just not true. State auditors blow the whistle on gimmicks that involve Federal spending on a daily basis.

I will show you. In fact, I would ask the leadership of the State auditors organization, why do not you give us examples across the country so we can get some sampling of the kind of audits that are done to shake up State policymakers about the way Federal dollars are being spent.

Chairman JOHNSON. Again, I am not saying they will not blow the whistle on some, but you certainly need a Federal oversight role here. That is the point I am making.

Second, you started out your questioning really about Obamacare and guaranteed issue. We do have plans. There is a plan right now. I would love to vote on it, Graham-Cassidy-Heller-Johnson, which would more equitably distribute the Medicaid expansion and the advanced premium tax credit to the States. It is pretty much ready to go. It definitely preserves guaranteed issue.

By the way, I argued strenuously but unsuccessfully during the debate as well to have things like invisible high-risk pools in Maine that literally cut the costs for young people, their premiums, to a third of the current level and half for elderly individuals, while not doing away with guaranteed issue.

There are ways of doing this, and I am happy to have the debate. And I would love to take a vote on it as well.

That being said, our next questioner is Senator Peters.

OPENING STATEMENT OF SENATOR PETERS

Senator PETERS. Thank you, Mr. Chairman, and both of our witnesses, thank you again for being here today.

Administrator Verma, I was pleased in your opening comments when you talked about how Medicaid is absolutely essential to pro-

viding health care to folks in this country, and I hope that you are focused on the goal, which I hope all of us have, is that no matter who you are, no matter where you live, you should have access to quality affordable health care in this country. That should be our focus.

And as we are looking to make Medicaid more efficient, which we should, we have to make sure taxpayer dollars are being used the best way that they can. We look at that in the spirit of strengthening the program and the ability to make sure that those folks continue to get that care.

And when I raise that, I mean in particular to an epidemic that I am very concerned about, which is the opioid epidemic, which without question is a public health crisis in this country that we have to deal with, and Medicaid is front and center in dealing with it. In fact, most folks rely on Medicaid for substance abuse counseling. So, in that spirit, I have a few questions for you, and we all know that there is no silver bullet when it comes to addressing this crisis.

But many health experts are looking at medication-assisted treatment (MAT), as kind of the gold standard for treating folks who are suffering from this addiction. We have seen this approach be used successfully in other countries over the years; in fact, in France in the 1990s which had a very serious heroin epidemic, used this treatment to dramatically reduce—in fact, by over 80 percent—the amount of deaths associated with overdose.

So my first question is to you, What steps are you taking at CMS to expand access to medication-assisted treatments?

Ms. VERMA. Well, thank you for your question. I appreciate it.

On a couple of issues in terms of dealing with the devastating effects of the epidemic and substance use disorder at large, as we look at this issue, one of the major steps that we have taken is to make sure that individuals on the Medicaid program have access to treatment, and we know that there has been some barriers to obtaining care with some of the existing Medicaid policy around institutions for mental disease (IMDs). Those institutions were not available to individuals on the Medicaid program.

And so one of the things that we have done is to put out guidance to States in particular around waivers so that they could have a waiver of this law and to allow Medicaid recipients to obtain care at the IMDs. We think this has been an important step in terms of improving access to care.

The previous Administration had taken action on this but had put in place a lot of up-front barriers requiring States to put a lot of different things in place before they could even start accessing the treatment. So we have changed this around, allowing individuals to have that immediate access to care while asking States to put together a comprehensive plan that would include addressing medication-assisted therapy.

By doing that already, we have approved 11 waivers today. We have nine that are continuing to pend that we will be hopefully addressing very soon.

In terms of your question on Medicaid-assisted therapy, I think that is an important issue, and I would like somebody from my

staff to follow up with you as soon as possible on some of our efforts on that, so thank you for the question.

Senator PETERS. Well, I appreciate that. We will follow up, and you actually answered my second about the guidance to the States, so I appreciate that. We have to keep pushing that out to make sure that the States are responding appropriately and have proper guidance from CMS.

The second question relates to community health centers who have been adapting their services, as you know, to respond to the opioid crisis, particularly the extent to which they offer Medicaid-assisted treatments.

Health centers disproportionately serve populations on Medicaid or without any insurance whatsoever, which together account for nearly half of non-elderly adults with opioid addiction. They are also located in medically underserved rural and urban areas, which are typically, as you well know, the hardest hit by the crisis.

The survey found that health centers in Medicaid expansion States are more likely to provide Medicaid-assisted treatment than those in non-expansion States, and they are more likely to increase the number of providers who can prescribe these medications and are much less likely to rely on Federal grants for the training.

In addition, they distribute the Naloxone, the life-saving drug for reversing the effects, at almost twice the rate as in non-expansion States, and this tells us that when more folks affected by the opportunity crisis can pay for their services through Medicaid versus no insurance, health centers can provide more and better treatment to other folks as well.

So my question is, How would you describe the role of Medicaid in treating individuals that suffer from opioid addiction, and what can we do to make that even stronger?

Ms. VERMA. So, generally, I would say that across the board, with all of CMS's programs, whether it is Medicare, Medicaid, or exchange programs, having access to coverage increases an individual's ability to access treatment, and we certainly acknowledge the important role that community health centers play in serving our safety net populations. And we appreciate their efforts.

Senator PETERS. So you see Medicaid as a positive resource for individuals who are suffering from opioid addiction?

Ms. VERMA. It can be.

Senator PETERS. It can be? How can it be—why would it be a negative?

Ms. VERMA. I think there has been some concerns that have been raised in terms of having providers in the program that may not have been screened appropriately that were providing medications inappropriately, and that is not necessarily an issue that is just a Medicaid issue. It is also across all potential insurers as well.

Senator PETERS. So, no question, there are problems with efficiencies and whether or not there is fraud, whether or not there is inappropriate prescribing, but on balance, these are programs that are absolutely essential for us to deal with this crisis. Would you agree?

Ms. VERMA. I think it is important for people to have access to treatment.

Senator PETERS. OK. Thank you.

Chairman JOHNSON. Senator Hassan.

OPENING STATEMENT OF SENATOR HASSAN

Senator HASSAN. Thank you, Mr. Chair and Ranking Member McCaskill, and thank you to both of our witnesses for being here today.

And I just want to know, Administrator Verma, I appreciated very much your comments about the importance of protections for people with preexisting conditions. One of the things a number of us are eager to hear in the upcoming hearings on the Supreme Court nomination of Judge Kavanaugh is for him to clarify his position because he has written some remarks that indicate that he perhaps does not believe that it is constitutional to require coverage of those with preexisting conditions. So it is one of the things I am waiting to hear through the hearing process and the confirmation process.

But I wanted to turn to an issue that I think many Americans are concerned about, Administrator. At the beginning of the month, the Administration finalized a rule to allow insurers to sell short-term junk health insurance plans to cover people for up to a year. These are skimpy plans, and some would hardly even describe them as health insurance at all. They would expose consumers to a tremendous risk and come without many of the most important protections established by the Affordable Care Act.

These junk plans can deny coverage, exclude benefits, or charge higher rates to people with preexisting conditions, and they do not even have to cover all of the essential health benefits like maternity care or prescription drugs.

This junk insurance rule is just one of a litany of actions that the Trump administration has taken to sabotage the Affordable Care Act. I really think putting politics over patients.

I cannot understand why the Administration would finalize a rule like this, given how much the American people have made it clear that they value comprehensive coverage and protections for preexisting conditions.

Administrator Verma, the Administration has said this junk insurance rule will provide people with more options, but if a person with heart disease is denied coverage by a short-term plan, how is this an option for them? If someone with asthma tries to buy a short-term plan and is told it will cover everything except their asthma medication, how is this an option for them?

If a woman or an older adult tries to buy a short-term plan and they are quoted a price they cannot afford because of their age or gender, how is that an option for them?

Ms. VERMA. Thank you for your question.

Short-term limited duration plans are about giving choices to Americans. Today, there are over 28 million Americans that are uninsured. They cannot afford Obamacare's high rates.

Senator HASSAN. Certainly, more people are insured today because of Obamacare than before Obamacare, correct?

Ms. VERMA. And rates have gone up over 100 percent. In your State alone, in New Hampshire, since 2014, rates have gone up 64 percent.

Senator HASSAN. You know how much they went up between 2002 and 2003, if I have my years right? It was, for some people, about 200 to 300 percent. So the rise in insurance premiums has not been a product of the Affordable Care Act alone.

I have a son today who is alive because of the research and development (R&D) in the medical field that allows him to have a baclofen pump, somewhere between 10 and 15 different high-cost medications, a feeding tube, and a bunch of other things—and home nursing, right? He would not have been alive a generation or two ago.

So let us just talk about these short-term plans, OK? Because the concern here is that we are saying to people, “Hey, you can spend less money on a short-term plan,” and then when they actually need coverage, they find out that the money they spent does not cover it. So how is that better for them?

Ms. VERMA. So there are individuals today that cannot afford anything because of the high rates. This is intended to give them a choice, an alternative.

Now, I am not saying that this is for everybody, and what we have done is to strengthen the consumer protections. We make sure that individuals are aware of what they are buying and what the limitations are, but the reality is there are so many individuals in our country, 28 million people, and the rates have gone up over 100 percent. There is limited choice. There is limited networks.

Many of the plans that are being offered have high deductibles that people cannot afford, and these—

Senator HASSAN. Which was also true before the Affordable Care Act.

Ms. VERMA. The short-term limited duration plans were available before Obamacare and at the beginning of Obamacare.

Senator HASSAN. They were available for much shorter times. They were intended as a stop-gap between jobs. They were not intended as something to mislead consumers about the coverage they would get, and there are other methods we could take, some of which you heard from the Ranking Member, that could help us reduce health care costs overall.

So let me turn to some of the other ways where we could really be getting at health care costs. As drug prices continue to skyrocket, one particular area I continue to focus on is how we can stop big pharmaceutical companies from taking advantage of patients and our health care system. Big pharma is endlessly creative when it comes to ways to game the system and pad its pockets.

So let us take the Medicaid rebate program. Drug manufacturers have to provide rebates or discounts to States as a condition of having their drugs covered by Medicaid. States then share that discount with the Federal Government.

Manufacturers are supposed to give larger discounts for brand drugs, which are typically more expensive than generic ones.

But true to form, some drug makers may have misclassified their drugs in order to shirk their obligation to provide that larger discount, leading to more than \$1.3 billion in lost discounts from drug manufacturers from 2012 to 2016.

People might remember this issue from when Mylan, the maker of EpiPen, misclassified the EpiPen as a generic drug.

So, Administrator Verma, how is CMS tracking the classification of drugs in the Medicaid rebate program to see if there are any misclassifications?

Ms. VERMA. So, first of all, in terms of the classifications, I will add in terms of the Medicaid rebates that the Affordable Care Act actually capped the amount of rebates that manufacturers had to give. So, even as they have increased their prices, the Affordable Care Act actually capped the amount of rebates.

But in terms of the misclassifications, I agree with you this has been a significant issue.

Senator HASSAN. Yes.

Ms. VERMA. We know in the case of Mylan that there was definitely an issue there. We worked around a settlement of that, that came to about \$465 million that came back to taxpayers.

What CMS has done is put out guidance to manufacturers to make it very clear to them what the requirements are regarding the classification.

The problem that we have, however, is that we do not have any enforcement authority. So we can put out guidance, but if they are not—

Senator HASSAN. Right.

Ms. VERMA [continuing]. Classifying appropriately, then we are limited in the amount of action we can take.

Senator HASSAN. So that was going to be—and I realize I am running out of time, but my last piece of this question, I was just going to ask you, Would you support additional authority from Congress so that CMS can impose civil monetary penalties on drug makers who knowingly misclassify their drugs in the Medicaid rebate program?

Ms. VERMA. Yes, we would, and I think that our efforts around the Mylan settlement—

Senator HASSAN. Right.

Ms. VERMA [continuing]. Shows the amount of dollars that taxpayers are losing, and so we would be very supportive of that.

Senator HASSAN. Thank you very much.

And thank you, Mr. Chair.

Chairman JOHNSON. Senator Hassan, I do want to point out, short-term limited duration plans are a part of Obamacare.

Up until just leaving office, those things were for a term of 364 days. On the way out the door, President Obama restricted those to 90 days. So individuals that have been seeing their premiums double, triple, quadruple, simply could not afford it, and they were being forced to buy these limited plans 90 days at a crack—so now what the Administration does is made those—return them to where they were, 364 days, and allowed renewability for up to 3 years. If people end up with a preexisting condition cannot renew them, you have the Obamacare exchanges.

So, again, this is just giving an option. It is going to dramatically lower premiums for people that have been priced out of Obamacare markets. It is called freedom.

Senator HASSAN. Mr. Chair, if I may?

Chairman JOHNSON. Sure.

Senator HASSAN. If they have an event that—with a preexisting condition during the time that they are covered by that short-term plan and it is not open enrollment on the exchange, they are stuck.

And, second, what we also know is that by extending what—these short-term plans were supposed to be here between jobs. It is minimal coverage while you move to your next long-term plan. What we know is it is going to drive the costs up for everybody else. That is what we have good data about.

So I am happy to have this debate, but the reason they are limited in duration is because you have people spending hard-earned money on junk insurance that does not cover lifetime illnesses and events.

Chairman JOHNSON. And the reason they are needed is because—

Senator HASSAN. And then the rest of us will pay for it.

Chairman JOHNSON. And the reason they are needed is because Obamacare for individuals have been priced out of the market, double, triple, quadruple the premiums. That is why. So we are trying to give some option to those people that have been—the forgotten men and women of Obamacare.

With that, Senator Carper.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. I am going to say something I had not planned to say. One of the things we, every now and then around here, actually work together, and to the best people we have Lamar Alexander and Patty Murray. And some of us were invited to participate less than a year ago in a series of hearings and a series of offsite coffees that preceded those hearings to try to figure out what are some things we can agree on to bring down the cost of coverage in the exchanges.

And the witnesses included Governors. They included State insurance commissioners, folks from health insurance companies, providers, you name it, and they basically agreed on three things. It was kind of amazing. First, they said at the end of the day, what we need is to adopt an approach on reinsurance, maybe sort of like what we have in Medicare Part D, but that would be a good step.

Second, they said that cost sharing reduction (CSR), we need to make sure the cost-sharing arrangement, so that they do not go away, that they are going to be around, the insurance companies can count on those. They have some certainty.

The third thing—the witnesses agreed one after the other was that if we are going to get rid of the individual mandate, we have to come up with some combination of alternatives, which in their aggregate mimic the effect of the individual mandate.

We have some witnesses who said the reduction in premiums in the exchanges could be 25, 30, or 35 percent if we would do those three things, and regrettably, we have never voted on that package, which is just beyond me.

One of my best friends, this guy named Kasich from Ohio, we were freshman Congressmen together 400 years ago, and he was asked why he decided to extend Medicaid in the State of Ohio a few years ago, Medicaid expansion up to 135 percent. And he said, “When I stand at the pearly gates someday in the future and I am

trying to get into heaven and they ask me what did you do to deserve getting in”—and I am paraphrasing him, but he said, “I just want to be able to say that when people needed health care, I helped them get it.”

And when you read Matthew 25—my colleagues hear me quote Matthew 25 from time to time—it says, “When I was hungry, did you feed me? When I was naked, did you clothe me? When I was sick and in prison, when I was thirsty, did you give me to drink when I was a stranger in your land?” It does not say anything about health care. It does not say a word about when I did not have any access to health care, did you do anything about it.

And Kasich says, “Well, I want to be able to say we did something about it.”

I think we have a moral imperative to the least of these in our society, and as we are talking about here today, we have a fiscal imperative because States face big fiscal challenges. We do in other States too, and frankly, we in the Federal Government face big fiscal challenges.

And so the timing of this hearing is ideal and it is important. I have focused for years on improper payments. A bunch of my colleagues have worked in those fields with me, and so has Gene Dodaro and our friends at GAO.

I have a question on program integrity, and I want to ask Mr. Dodaro.

Ms. Verma, I always note Gene Dodaro—if you will notice, not a word on a piece of paper. He just sits there and gives a statement, and then he answers questions. For the first few times that he did it, first couple of years, I was like really amazed, and then I noticed this lady who has like a white coat, right behind him over his left shoulder. When he speaks, I see her lips move. [Laughter.]

She is always there. So we welcome you both.

A question for Gene. Earlier this year, as you may know, Senator McCaskill, Senator Johnson, and I introduced yet again more improper payments legislation, and it was called the Payment Integrity Information Act. And the bill takes a series of steps or at least attempts to take a series of steps to address the problems of improper payments across our government, including the formation of a working group that will enable Federal agencies to collaborate with each other and with non-Federal partners, such as State governments, to develop strategies for addressing key drivers of improper payments.

And I would just ask, Mr. Dodaro, should this bill become law—and it just might—what would you advise this working group to focus on in order to combat improper payments in the Medicaid program? What advice would you have?

Mr. DODARO. First, I am very supportive of the legislation. I hope that it becomes law.

Senator CARPER. Would you like to be added as a cosponsor?

Mr. DODARO. Well, Senator, I do not think the rules will allow that.

Senator CARPER. All right.

Mr. DODARO. But from my vantage point, I think it is a good piece of legislation. I think it would advance the focus on improper payments. The advice I would give to the working group would be

to focus on the managed care portion of the Medicaid program. That area has received very little attention over the years. CMS is beginning to take action on that area, and I am very pleased with what they are planning to do. But I think more needs to be done in that area.

I would also encourage them to have some State auditors on their working group to work together with them as they develop their strategies. As the legislation is currently configured, most of the people on the working group appropriately are Federal officials, but I think they ought to bring in some State and local auditors as well.

This was done on the Recovery Act, and I think to great success in helping to eliminate, minimize fraud, waste, and abuse, and I think it could be done here as well.

So we have a lot of other more technical recommendations we can give the working group, but those would be my main points.

Senator CARPER. Good. Thanks.

Another one for you, Gene, but Congress has mandated that States submit Medicaid data to CMS to create, I think, a national database of Medicaid data. It has an acronym, as you might imagine, T-MSIS.

GAO has also found that States are delaying in providing Medicaid data to CMS, both for expenditures and for utilization of health care services.

And I would just ask, what should Congress do to help States report data to this entity, T-MSIS? What should they do to help States reporting in a more timely, efficient, and accurate manner, and what resources do CMS and the States need to adequately report data to CMS?

Mr. DODARO. The States are beginning to report the data now, but I think our concern is that the data be accurate and complete. I know CMS is beginning to follow up on this. I think that it would be appropriate to ask CMS to regularly report to the Congress on the quality of the data and ask GAO to evaluate that as well. This would also allow States to do comparability assessments to compare their Medicaid program to other Medicaid programs to learn good lessons.

The data are starting to come in now. This is a very important issue because in the past, the data was 2 and 3 years old. This requires monthly reporting, but the reporting data is only one step. The data have to be good. It has to be complete and accurate, and I think that is the next challenge here for CMS and the States.

But Congress can help by regularly monitoring what is going on in this area and encouraging greater actions by the States as well as by CMS.

Senator CARPER. Good.

Mr. DODARO. And GAO will be happy to help. We will be watching this.

Senator CARPER. Good. Thanks. Thanks so much.

Ms. Verma, if we have a second round, I will be pleased to ask some questions and direct them to you.

Ms. VERMA. thank you.

Chairman JOHNSON. Senator Heitkamp.

OPENING STATEMENT OF SENATOR HEITKAMP

Senator HEITKAMP. This should concern everyone. There is no doubt about it. The question is can we afford it, and if we cannot, how do we solve this problem? So no one here should pretend that we do not have a problem.

But one thing that gets absolutely lost in the back-and-forth on Obamacare is we should be talking about health care. We should be talking about the increased cost of health care, and so if we could all just turn away from our politics for a minute and go directly to solving the problem, we would go a lot further.

So there are three ways we can solve this problem. We can address waste, fraud, and abuse. We can improve efficiency in delivery, and we can reduce the amount of health care that is being accessed. All of those things would go a long way.

The RAND Corporation did a study, and the study said 12 percent of all the people in this country who have four or more chronic conditions cost the system 40 percent. What are we doing to address that?

Seema, when you look at this, have you seen it increase? North Dakota is a 50 percent State. We were as high as 80 at one point before the Bakken boom. So are you seeing an increase in the amount of Federal share overall in traditional Medicaid?

Ms. VERMA. Yes. I mean, I think that is the concern that we have, and Senator Johnson brought this up in terms of where we are with the GDP.

Our actuary projects that by 2026, we are going to be spending one in every five dollars on health care, so we are deeply concerned.

Senator HEITKAMP. Right, but that is not what I am asking.

The State and Federal Government share the cost of the Medicaid program. So what percentage today overall, nationwide, of the Medicaid program does the Federal Government spend?

Ms. VERMA. Well, there are different matching rates, depending on the population that we are serving, right? So if we look at where we are over the next 10 years, our actuaries project that we are going to be spending about \$998 billion—

Senator HEITKAMP. But what percentage of overall Medicaid spending is that?

Ms. VERMA. It depends on which program.

Senator HEITKAMP. Yes, but—

Ms. VERMA. For able-bodied adults, we are paying—the Federal Government is paying 90 percent, and it depends on the match rate.

Senator HEITKAMP. Yes. No, I mean, this is an important question because as we look at the economic challenges, State by State, some States are wealthier than other States. If you have a large State, that is not as wealthy.

Maybe you can answer this: What is the current Federal Medical Assistance Percentages (FMAP) on average in Texas?

Ms. VERMA. I think the FMAP in Texas is probably a little bit—60s? About 65 percent.

Senator HEITKAMP. Yes. And if that goes up to 70, you are going to have increased cost.

So this does not help me much because I do not know what is driving this other than utilization.

And so this is supposed to be a hearing about waste, fraud, and abuse, and I think that I share Senator McCaskill's point of view about the need to work with State auditors. They have real skin in this game.

I had my director of the Department of Human Services tell me that 28 percent of his budget went to pay for less than 3,000 people in nursing homes. Now, that is something we need to talk about, and so instead of talking about all the things that we get bogged down into, let us talk about health care.

So when you look at waste, fraud, and abuse, and you look at the programs, are you committed over at CMS, Ms. Seema, to responding and to having ongoing and consistent reports back to this group about the Medicaid program?

Ms. VERMA. Absolutely. And I think that this year since I have come to CMS, we have taken a lot of different actions.

One of the things when I came to CMS, we inherited a backlog of—

Senator HEITKAMP. Yes, I know.

Ms. VERMA [continuing]. GAO and OIG recommendations.

Senator HEITKAMP. I do not think anyone should put any blame. We had 13 years of inattention, but we have an opportunity today to take that first step toward solving this problem. And I want to make sure that you are working with GAO to respond.

There is a number of GAO requests, but this is a very high priority for our oversight.

Ms. VERMA. I completely agree. We have made this a priority in the organization. We meet with the GAO and OIG regularly. We have taken action. We have taken action on the backlog of disallowances. We have addressed some of the improper payments that were going on with the Medicaid program in California, for example, where we recovered by the end of this year, \$9.5 billion.

We have also closed some of the loopholes in the designated State health programs up to the tune of \$25 billion.

The disallowances, that was \$590 million that we went back and addressed.

We are also doing some of our own audits around beneficiary eligibility as well as managed care audits. We are restoring the payment error rate measurement (PERM), the PERM audits as well. We started doing those.

So we have taken a lot of actions, and I agree that we need to do more.

Senator HEITKAMP. Mr. Dodaro, let us assume that we run a perfect system and there is no waste, fraud, or abuse. How much do we reduce this number?

Mr. DODARO. Probably marginally.

Senator HEITKAMP. Yes. And that is the point, is that we need to spend every dollar critically, but at the end of the day, that is not going to solve our problem with this explosion of Medicaid costs.

This is a product of aging, aging into the system. It is a product of increased percentage of older, oldest who have depleted their resources, where we need to take a look at investments and research

that is going to help people live in their homes longer and not access these programs.

We have real work to do here, and it frustrates me to no end that we do not begin to address the things that can, in fact, make a difference long term.

And so I think that one of the next steps is how do you deliver health care in States like mine, and I want to publicly thank Ms. Verma for working with my office and working with me to talk about rural health care delivery.

I know the article that was in the New York Times that relay the situation in Claire's home State was absolutely eye-opening, and it tells us we need to do better, especially for those seniors who rely on this program.

But we have to start identifying those things where we can actually save money and save money long term without curtailing people's access to care.

And I want to just say one thing. It is disingenuous—and I am not talking about you because you did not make this decision, but it is disingenuous of this Administration to say they believe in preexisting conditions, protections in Federal law for preexisting conditions, when they are currently in court arguing that they are unconstitutional. There is nothing consistent about that position.

Now, I understand the complications with preexisting conditions and the complications with eliminating the individual mandate and preexisting conditions, but let us not pretend that there is any commitment here from the Department of Justice to preserve preexisting conditions as a protection for the American public because you do not go to court and argue that it is unconstitutional if you intend to preserve that protection.

So it is not your decision, but I want that on the record.

Chairman JOHNSON. Senator Heitkamp, thank you.

A quick answer to your question, off of this chart, according to CBO, it is about 72 percent, the \$430 billion, 72 percent of the \$600 billion total spend, when you combine the two types of Medicaid expansion and core Medicaid.

And then there are multiple causes in terms of why health care spending is a growing—take a look at this first sheet. This is kind of an interesting one.

Senator HEITKAMP. I saw it.

Chairman JOHNSON. I appreciate that. Senator Daines.

OPENING STATEMENT OF SENATOR DAINES

Senator DAINES. Chairman Johnson, I want to thank you for your continued attention to this important issue. I do hope the Democrats and Republicans can make some breakthroughs here. This is a chance for bipartisan ship.

I respect Senator Heitkamp's comments. There are multiple factors driving up this spending, but the scope of this hearing is to take a look at Medicaid fraud, Medicaid overpayments, and that is, I think, an important place to start, where I think there is probably some of the lowest-hanging fruit for us, perhaps in this area, that I hope we can agree on because if we fail to do this—these are important safety nets that we have in not only Medicaid, but I would argue Medicare.

If Medicaid spins out of control in terms of spending, it puts all of these important safety nets at risk, and we need to insure we safeguard these important safety nets for those who truly need it.

These improper payments in Medicaid, these exponential growth rates have been problems for years. I am struck by the fact that by—I think it is about 2022, Mr. Chairman, where Medicaid spending all in the Federal component, the FMAP, plus the State component exceeds Medicare spending—and about 2022 is when those numbers cross is my understanding, some, what, \$835 billion, all in number in Medicaid compared to \$828 billion in Medicare. And I do not think that is being talked about enough right now.

We talk a lot about the challenges of ensuring we keep Medicare protected long term, but Medicaid spending will exceed Medicare spending all in.

And the numbers, Administrator Verma, that you shared about California alone, that \$9.5 billion, that is real money. I think about how hard we fight on Capitol Hill, like on the Land, Water, and Conservation Fund (LWCF), for example, to try to get that fully funded. We could take 5 percent of the California savings and fully fund LWCF.

I think about the backlog in our National Parks. I chair the National Parks Subcommittee. We have about a \$12 billion maintenance backlog, of deferred maintenance. That is debt in our National Parks. The California \$9.5 billion recovery that you all have made just about takes care of our National Park deferred maintenance for the entire country. so these are important discussions.

Administrator Verma, I applaud your efforts to improve the program's integrity. The waste, the fraud, the abuse in Medicaid is appalling, and now we have millions of healthier working-age individuals who are being added to this program.

Enrollment in my home State of Montana has exploded and far exceeds the initial actuarial projections.

My question is, Are you concerned that providing care to the expansion population could bring about even more misuse of taxpayer dollars?

Ms. VERMA. So if we look at Medicaid expenditures for adults, newly eligible adults, these are projected to amount to \$806 billion over the period of 2016 through 2025, so it is an extraordinary amount of dollars.

Senator DAINES. On the expansion.

Ms. VERMA. On the expansion population alone.

Senator DAINES. Right.

Ms. VERMA. And if you look at the structure of that, it is 90 percent eventually that the Federal Government will pay for this, and so I think that that diverts the focus from the rest of the Medicaid program, the most vulnerable populations.

In terms of program integrity, this is why we are deeply concerned about this. We have always had program integrity efforts within the Medicaid program, but given now the change with the match rate—and it is not only 90 percent, but it is a completely open-ended entitlement—

Senator DAINES. Right.

Ms. VERMA [continuing]. The incentives are not in place necessarily for the State to focus on program integrity because as they

are recovering dollars—for example, if they have budget cuts or if they are focusing on program integrity for the expansion population, they are only going to recover, only up to 10 percent. So that is why I think it is incumbent on the Federal Government to have a renewed and more focused attention on this.

Senator DAINES. Administrator Verma, you have worked both the State side as well as the Federal side. You have worked with Vice President Pence when he was Governor.

So if you put your hat on, if you were a Governor, and you had basically an FMAP of 90 percent to 94 percent with the expansion population and you have, in Montana's case, about a 65 to 66 percent FMAP with traditional Medicaid—you talked about the incentives of integrity—arguably, would not there be an incentive perhaps for the States? As much as I strongly believe in the principle of federalism and empowering the States, but with an open-ended entitlement on the expansion, do you think there perhaps is an incentive for States to move traditional Medicaid enrollees and move them on the expansion FMAP? Because the algebra is pretty simple.

Ms. VERMA. Yes, absolutely. And I think that is why we are focused on doing more audits around eligibility because we know that there have been problems with this.

Some of the audits have shown—that the GAO have done, that we know that there has been system errors, whether some of these are worker errors, but you are right. At the end of the day, with that 90 percent match rate, States have a strong incentive to draw down more Federal dollars.

I think also, in terms of their support of the program, that those are dollars that they are putting toward able-bodied adults that they are not putting toward vulnerable populations.

We know that access to care in Medicaid has been an issue in terms of provider reimbursement. So those are dollars that they are not putting toward vulnerable populations, increasing rates to providers, and that they are putting for able-bodied—

Senator DAINES. Arguably, we are subsidizing at a higher rate able-bodied individuals at the expense of what Medicaid is originally intended to protect, which are those who are truly the most vulnerable in our society that do not have any other options. It is just a concern.

Ms. VERMA. I think it is a concern.

I think also the structure of how we have set this up, with a 90 percent match and an open-ended entitlement, it really does create an incentive for the States to spend more and more.

So as we are looking at program integrity at large and we think about all of the efforts that we are taking and we appreciate the support of the GAO, the State auditors, but at the end of the day, we are constantly going to be—if we come up, we audit. We find problems; we correct them. States are going to figure out new ways, and until we change the dynamic and the structure of the Medicaid program from being an open-ended entitlement to one where States are responsible for a fixed amount of dollars, we are always going to have these issues around program integrity.

Senator DAINES. You mentioned GAO. Last question over to the General.

General Dodaro, to follow up on our conversation about 2 months ago, is GAO analyzing improper payments data pertaining to the expansion population?

Mr. DODARO. Yes. We have looked at that issue, raised a number of recommendations to CMS to address. For example, in some States, they have asked CMS to do the eligibility determination for them, but they need to check to make sure they have good quality controls in place. So that is a good step forward. They are putting that in place. We are checking it, and that should be OK.

The other thing is that they need to make sure they are checking because some people can move between Medicare—or the Medicaid program itself and the exchanges, and they can go back and forth, depending on their income, their employment status as well, and that needs to be measured because there are different payments that accrue to them because of this.

And then there are also inconsistencies in eligibility determination, both for financial and nonfinancial data, that need to be resolved.

So we have looked at this. We have made recommendations. CMS is taking action. In most of them, we have closed it. In some areas, we are waiting for additional documentation.

Senator DAINES. Thank you.

Mr. Chairman, I think there will be a spin in others who would seek to try to perhaps challenge the motives of what this Committee is trying to do, but I think—let us be clear. We want to make sure we protect and that we save Medicaid and Medicare, and by doing so, by eliminating the waste, fraud, and abuse or minimizing it, that is the best way to ensure those who need it the most will continue to see those benefits.

Thank you.

Chairman JOHNSON. Thank you, Senator Daines.

Now, my staff tells me that Senator Jones is next. Is that true?

OPENING STATEMENT OF SENATOR JONES

Senator JONES. All right. Thank you, Mr. Chairman, and thank you for the witnesses for being here.

Let me first—I just want to echo something that Senator Heitkamp said, and I know, again, it is not there. But I want to also talk about this preexisting condition issue because I have just spent the last couple of weeks in a couple of roundtables with listening to people affected, 900,000 people in Alabama affected by preexisting conditions. And that is just the people affected, not just their families.

I agree with Senator Heitkamp that I am just stunned at the way that the Administration is saying they want to protect that, but at the same time taking actions that are scaring my citizens to death that they are not going to be able to have insurance.

I just came from a Banking hearing involving sanctions, and the mantra of the Administration is watch what we are doing on sanctions, not what we are saying.

Here, it seems to be just the opposite, that watch what we are saying and not what we are doing. So to the extent that either of you can have any influence, please try to alter the course of the Administration with regard to preexisting conditions. Thank you.

Ms. Verma, let me ask you real quickly. The Medicare wage index is a real problem, and I know you have seen letters from members of my delegation. Alabama is at the lowest level on that, and we were hoping there might be a little relief in the most recent inpatient perspective payment system rule that came out in August, but we did not get that.

How can we best work together to find a solution to that for my State? I mean, we are having rural hospitals closing left and right, and it is everywhere I go. The first thing they say is it is because we are just not getting the same amount of reimbursement.

What can we do together to try to get that changed, short of a full-blown legislative fix that may or may not ever happen?

Ms. VERMA. Well, thank you.

I appreciate the issue that is going on in Alabama with the hospitals, and I had an opportunity to meet with some of the hospitals and the hospital association—

Senator JONES. Right.

Ms. VERMA [continuing]. And appreciated their input. And I am deeply sympathetic to the issue that they are facing in Alabama.

I think the wage index is something that we are concerned about, and so what we did in our rule was to put out a request for information (RFI). That gives us an opportunity to hear what the impact has been on the wage index, and that is something that once we have that input, that gives us a basis of looking at the methodology.

I am concerned when there are these types of disparities, and whether you are a hospital in a rural area, you are still paying the same amount for equipment.

Senator JONES. Right.

Ms. VERMA. And so we do need to address that issue.

I am concerned about the closing of hospitals, and I want to make sure that all Americans have access to care, whether they are in a rural community or whether they are in an urban community, so this is something that is important, which is why we started out with putting an RFI. And this is something that we are going to be looking at next year, so I appreciate it.

Senator JONES. Great.

Well, I am assuming from your answer that I can get your commitment to continue to work with our office and the other members of the delegation to try to address that.

Ms. VERMA. Absolutely. I look forward to working with you on this.

Senator JONES. Wonderful.

The other thing I want to ask, Ms. Verma, is about the Medicaid exemption that Alabama has just recently requested and I think has been sent back now.

Alabama is trying to impose some very strict work requirements for Medicaid recipients I think in trying to oppose like 35 hours of work. Alabama has incredibly strict guidelines to begin with. It is very low, and the way I see our failure to expand Medicaid has essentially turned this work requirement into a work penalty.

And I know that has been sent back, but I would like to have a little bit of information from you because I am strongly opposed to what the State is trying to do because it is a Catch-22 when peo-

ple that are barely making above the poverty level are either going to have to work or have insurance. That is just it. So it is a real Catch-22.

So how are you going to be looking at that? Are you going to be looking at factors about how it is going to impact the children, how it is going to impact families that need child care options? Are you looking at Head Start and those things? What is going to go into effect? How are you going to look in evaluating whether or not Alabama gets this exemption for what I think is an ill-conceived requirement?

Ms. VERMA. So let me speak generally to the issue of community engagement. Our guidance came from requests from States, many States trying to address generational poverty, trying to do something with the Medicaid program to address that issue to help people find a pathway out of poverty, independence, finding a pathway to have the dignity of work.

It is also about improving health outcomes, and so that is really where this was borne out of, were these particular requests.

We know that the old way has not worked when people have been living in poverty for so many years, and I think this is about trying something different, trying to improve the lives of Americans.

When we put together the community engagement guidance to States, one of the things that we ask for is that they consider special populations so that there are some populations.

This does not impact children. It does not impact people living with disabilities. It does not impact pregnant women. It does not impact individuals that are medically frail or individuals that are addressing substance use disorder.

So when States are putting together their community engagement proposals, we have asked them to address these issues, address exemptions. There might be parts of the States that may not be appropriate or may not have jobs available, but I think at the end of the day, the work participation rates in the United States have gone down. They are some of the lowest that we have seen in many years, and we know that there is a lot of jobs that are available. So this is the idea of helping people to obtain independence and obtain the skills that they need.

They can also participate—it is not only about work. It could be—community engagement means volunteer work. It could be job training. It could be participating in school. So there is a variety of different ways that individuals could potentially meet these requirements.

In the case of Alabama, we have also asked what is the transition. We want to make sure that there is a pathway. So we have asked them to look at their proposal. We do not want to make sure there is some type of a subsidy cliff. We want to make sure that that is smoothed out, and so we have asked them to provide us some more information on that, and that is something that we will be looking at as we consider their proposal.

Senator JONES. Well, I would urge you to take that laundry list of folks of impacted citizens that you looked at and look very carefully at Alabama because my belief, based on what I know, is that every one of those groups are going to be impacted significantly,

particularly children of single parent, single moms who are going to have to go back to work and will either not get their health insurance. So I would just urge you to take a close look.

I know that in the community surveys, there was some—I think roughly 800 comments, and 759 of those from hospitals and doctors and stakeholders were absolutely opposed to this because they did believe that it would significantly decrease and hurt health outcomes in the State of Alabama. So thank you for that in your consideration.

So thank you.

Thank you, Mr. Chairman.

Chairman JOHNSON. Senator Hoeven.

OPENING STATEMENT OF SENATOR HOEVEN

Senator HOEVEN. I would like to thank both of you for being here today.

Administrator Verma, I want to bring up first something you and I have talked about previously, and that is Veterans Affairs (VA) reimbursement for long-term care for our veterans.

In the VA MISSION Act, we included language that expressly allows nursing homes to take VA reimbursement for veterans that come into a nursing home or a long-term care facility, as well as for in-home care products and services and the continuum of care, to take VA reimbursement on the same basis as they take Medicare or Medicaid reimbursement.

The reason that is important is because right now, only about 20 percent of the providers in North Dakota take VA reimbursement because if they take it, they are subject to small business contracting rules, which create a whole second set of inspections and regulatory red tape and bureaucracy that they have to comply with, which is difficult and costly.

So, as a result, our veterans have limited choices, both in long-term care facilities, but also in their home-based or community care-type products and services in the long-term care world.

And then they have to expend their own funds and dissipate their own savings until they are gone and then they qualify for Medicaid, and can get the long-term care services they need.

So this is a very important issue for our veterans, and that is why we changed it in the VA MISSION Act. The key now is that VA is putting the regulations in place. And it is very important that we do not create new regulatory barriers in place of the old regulatory barriers there by not accomplishing what we are trying to do.

So I am asking for your help and your support, and I have already approached the Department of Labor (DOL). The Secretary of Labor is on board with this. The Secretary of the VA is on board with this, and I want to make sure that you are on board. As these regulations are written, we want it to end up with one set of regulations and inspections and so forth, whether that be long-term care facilities, home based or institutional care, whether they are getting Medicaid, Medicare, or VA reimbursement.

Ms. VERMA. Yes. I think it is very important that our veterans have access to the care that they need and different choices about the care that they receive.

As you know, President Trump started something called Cut the Red Tape, and as part of that CMS has initiated our effort, which we call Patients Over Paperwork. And as we are talking about the high cost of health care, one of the things that we know drives health care cost is all the increase burden of administrative costs. So we are very concerned about anything that provides—or increases burdens to the extent that it does not improve patient quality and safety.

Medicare already has extensive regulations and guidelines for nursing facilities. So I think that as we are looking at this, it would be helpful for providers not to have to have two sets of regulations.

We also have a system of evaluating these facilities to make sure that they are in compliance with our regulations. So that is already in place, and we would look forward to working with you on this to make sure that health care facilities do not have to comply with two sets of regulations. We understand that that is a significant burden for them.

And to the extent that it decreases access to care for our veterans is something that we are very concerned about, and we would be happy to work with you on this.

Senator HOEVEN. Right.

Thanks for your help and support on this on behalf of our veterans.

As the Administrator for CMS, you are the person that is overseeing all the requirements for this reimbursement and certainly, if we trust you to do it for Medicare and Medicaid, that should work for VA reimbursement as well. So thank you for your help and support on this.

In regard to the Medicaid program integrity strategy, I would ask both of you, What are the very critical pieces that you feel have to be implemented that have the most impact or the greatest benefit? And what has to happen with the States in terms of their cooperation to really make it happen?

Administrator, you can start—

Ms. VERMA. Sure.

Senator HOEVEN [continuing]. And then if you could follow up as well, Gene.

Ms. VERMA. Well, there are many initiatives, and I can go through all of them. I think we provided that to you in our written testimony, and we agree with many of the GAO recommendations and are working to implement those.

But I would say that we are always going to be working on program integrity. Our work is never going to be done. We need to make sure that every dollar goes to the right place. As costs are increasing, we cannot afford to not make sure that patients have access to the care that they need.

That being said, I think the problems that we have are related to the structure of the Medicaid program because it is an open-ended entitlement, because there is so much Federal dollars that are involved here with the match rates, that we are always going to be chasing this until we go back and try to address the fundamental structure of the Medicaid program, to put it on a more sustainable path, to make sure that States have the appropriate incentives in place to address program integrity.

Senator HOEVEN. Now, when you say that, do you mean both FMAP as well as expansion, traditional FMAP as well as expansion?

Ms. VERMA. I think it is both. I think that the risk has increased now that we have a higher FMAP rate or that the Federal Government is paying 90 percent for the cost of able-bodied individuals.

But even in the base Medicaid program, the structure of the program, because it is an open-ended entitlement, it incentivizes States to spend more and more, and now with the 90 percent match rate, now there is more of an increased risk.

I think that going forward, we have worked extensively with the States on program integrity issues and will continue to do that working with the State auditors, but because this program for the able-bodied adults is funded 90 percent by the Federal Government, I think the onus is going to be on us.

A case in mind was California. We had an issue there with some of their payments to managed care organizations, and we found that they owed the Federal Government \$9.5 billion. So, I mean, we are always going to have to be looking at this issue, but I think the problem is the structure of the Medicaid program. It is an open-ended entitlement.

Senator HOEVEN. On traditional FMAP, we are a 50–50 State. So on traditional FMAP, is that a problem, too, even at the 50–50 structurally or not?

Ms. VERMA. I think so, but it is more of a problem for the able-bodied adult. So I would support structural changes to the Medicaid program to address the open-ended entitlement issue, more of an issue, though—

Senator HOEVEN. So it is the open-ended aspect—

Ms. VERMA. The open-ended—

Senator HOEVEN [continuing]. That you think drives the challenge with cost savings.

Ms. VERMA. Correct.

Senator HOEVEN. Mr. Dodaro, your thoughts? Again, where do you really see that area where 10 percent of the effort gets you the 90 percent result kind of thing versus the reverse.

Mr. DODARO. There are two main things that I think are really important and potentially game changers here. Number one is I think we need to bring the State auditors into the picture because they have the ability to monitor this on an ongoing basis at the State level on the ground and can provide a great degree of accountability and transparency, no matter how the program is structured.

The CMS actuary estimates that by 2025—about 7 years from now—total spending, Federal and State, will be \$958 billion. So we are knocking on the door of a trillion dollars a year for Medicaid spending.

Your main accountability people at the State level are there on a regular basis. This is a third of most States' budgets, so there are always incentives, no matter what the match is. The Federal Government and the State governments are all on a unsustainable long-term fiscal path. So there is going to be fiscal pressures and pulling and tugging, but you need that at the State level, number one.

Senator HOEVEN. Are they not there now?

Mr. DODARO. No.

Senator HOEVEN. They are not involved in that process?

Mr. DODARO. Not in any substantive way looking at improper payments on auditing managed care. Nobody is auditing managed care right now including the managed care providers, and this is about almost half of the Medicaid spending is managed care. How the providers are making the payments there, that has not been audited.

CMS, now has there is a rule. They are trying to change this. We have been calling for this for years. They are going to start doing some audits, but they have limited resources, and they are only covering the audits on a 3-year cycle with the States. So it will take 3 or 4 years to get through all the States.

The State auditors are there. They are doing financial auditing, but they are not doing performance auditing to focus on this area. It could be a game changer if we get them involved in a substantive and ongoing way.

At the Federal level, Ms. Verma is right. We need Federal protection as well, and our recommendations have been to ask CMS to be more specific and stringent on approving State demonstrations, to get more information on the sources and uses of the money States are using to fund their share of the program, that they are not shifting cost. So the Federal Government needs to be vigilant.

And while it is very appropriate—and I agree that States need flexibility—it has to also protect the Federal interest. And in the past, there have been approvals given to the States that have not protected the Federal Government's interest, and that is what is driving the cost.

The Administrator and I have had conversations about this, and she agrees. And, hopefully, they are going to move in that direction.

So you can give flexibility and accountability, but you also need to protect the Federal Government's interest.

Senator HOEVEN. Thank you.

Chairman JOHNSON. Thank you, Senator Hoeven.

Just during this hearing right here, I have already got about three, four, or five other ideas for more hearings. To start drilling down managed care would be one of these things.

I have a lot of questions. Let us first start talking a little bit about what you were talking about with Senator Hoeven and Senator Jones about, and I would call it the unintended consequences of Medicaid expansion.

Administrator Verma, you talked about the reduction in work participate rates. I read a really interesting article written by Nicholas Eberstadt addressing that 20 percent of working-age adult males are permanently out of the workforce. More than half are on some kind of pain medication, oftentimes using Medicaid.

We issued a report based on that where we just in 3 days, when I asked my staff to take a look at the diversion, the use of the Medicaid card, get opioids and then divert that into the illegal drug market, more than 260 individuals or people being charged with exactly doing that. We found when we issued the report we got over 1,000. So that is an unintended consequence.

But another unintended consequence is if you have health care, it is a huge incentive to work, quite honestly, if you do not have it. So now all of a sudden the Federal Government is providing that to a working-age childless—some say able-bodied adult and you give them the Medicaid card where they can get a little extra income by diverting drugs, you have created a lifestyle.

So that also from my standpoint, when we talk about the 90 percent match, is a huge incentive for States to draw down those Federal funds, right? They only have to hit 10 percent, and if you throw the gimmicks, which we will talk about later, on top of that, you can pretty well get 100 percent, OK?

So talk to me about, both of you, what have we found in terms of the ineligible. What is the cause of that? California is a big problem there. I would think there is a huge incentive for States to transfer truly Medicaid-eligible individuals into Medicaid expansion if they can get away with it because they get a much larger match. Is that part of it? What else are you finding in terms of people that are ineligible that are part of that \$37 billion improper payment?

I guess I will start with whoever wants to take it first.

Ms. VERMA. Sure.

So if we look at the issue of eligibility and making sure that the people that are in the program belong in the program, when we looked at some of the GAO reports, some of those are system problems.

I am very concerned about system problems when we have invested at the Federal level millions, billions of dollars into these eligibility systems, and I think that we need to make sure that they are working appropriately. We certify these systems, and if we certify these systems and they are making mistakes, then I think that is a problem that we should hold individuals accountable for that. So there is that area of system issues.

There is always going to be worker errors that may be inadvertent that may be part of it, and then there is also beneficiary fraud. So there are sort of two or three areas with that.

What I am concerned about and one of the things that we are going to be looking at in terms of these eligibility reviews is looking at States where we have seen very high levels of enrollment that were beyond what was predicted. I think that is an issue.

You brought up the issue of are they putting populations that really should belong in a different category of Medicaid with a lower match rate, are they doing that. I think there has been some instances where that has been found. For example, a pregnant woman, they should be in the other program. So those are things that when we do our audits that we are going to be looking for.

In terms of individuals that are disabled, if an individual is receiving SSA or Supplemental Security Income (SSI), we should be able to have those types of feeds so that they are not being in the newly eligible category. So we need to make sure that the State systems are not doing that.

There are some States that do not use the Federal disability determination when they are making determinations around disability. So I think in those States, that is something that we need to review as well because we are not able to look at whether they

have already been classified under the Federal definition. So those are some of the things that we are going to be looking at.

The other thing that I would add is that when the GAO reports were done, they were done early on when States had just implemented the new eligibility system, the modified adjusted gross income. So it is possible that over time, States have improved their eligibility processing.

But something that we are concerned about, we have restored the payment error rate measurement audits. As GAO noted, those do happen every 3 years, but what we are doing is we are requiring States to do their own eligibility audits in the years in between. So those are some of the ways that we are going to address that, and I think our own audits will also address that issue.

Chairman JOHNSON. General Dodaro.

Mr. DODARO. Yes. I think Administrator Verma has given a very good overview of the issues.

I would just underscore the system problems. I think that is the only way, given the volume of what is going on over there, that you are really going to try to prevent these things up front. So there is an appropriate focus on this. There is appropriate matching, particularly for the income eligibility. There is good data that is available to cross-check against the self-reported data that people are providing.

I am very pleased that after a 4-year hiatus, they are back doing the beneficiary eligibility audits before. I really did not agree with the postponement of that. It happened in the prior Administration, and I am glad to see this Administration has plans to start these audits.

But when you make changes like we made in the Affordable Care Act, you should increase your internal control audits at the beginning, not step away and allow people to have extra time. So I think we have lost a lot of time over the last 4 years.

We are also starting more work in this area now. The time has passed, and we will be reporting to this Committee what we find in the future.

Chairman JOHNSON. OK. We will have a second round because I have more questions.

So with my limited time, let me go right to the audits. I think we should use every resource we have: State auditors; auditors within CMS, Federal Government; and then independent auditors. If we do that, particularly with independent auditors—this is for you, Administrator Verma—why not do all 50 States this year? Why not do it?

Ms. VERMA. So if we did every State every year, that would triple our cost. So I think that is always the issue that we are going to have with all of this which is—

Chairman JOHNSON. So what do you think your cost is right now in terms of auditing?

Ms. VERMA. In terms of auditing on the PERM, it is about \$34 million a year, so that would triple our expenditures.

Chairman JOHNSON. OK. When we are spending \$430 billion, \$30 million, I am happy to spend \$90 million on doing it right off the bat. I am dead serious about that. I think you really ought to aggressively go after this.

You are not going to have the audits honed the first year, but you have done it, and then we take a look at the results of that. I would highly recommend, let us get in all 50 States, and let us do the audits.

Again, you have independent auditors out there. I guess it is back down to the Big Four. When I was going to college, it was the Big Eight. But I would highly recommend that. Let us get in there and get them done.

And with that, I will turn to Senator McCaskill.

Senator MCCASKILL. I will defer to Senator Carper.

Senator CARPER. Thank you.

If I could just have 30 seconds. Thank you so much.

This has been a really good conversation, and it is one, frankly, I would like to see continue.

Gene Dodaro is really good about coming to Capitol Hill and meeting with us from time to time and going through his high-risk list that GAO produces every 2 years and see how we are doing in terms of making progress on that.

I do not know if it might be possible for you. I do not know if you come to Capitol Hill very much, but if you do, you might be willing to meet with some of us and our staff, both of you, maybe together, and to pursue some of these. I would appreciate it.

I would be remiss if I did not say one of the things I most like about the Affordable Care Act were the provisions that were originally sort of introduced by Senator John Chafee from Rhode Island back in 1993. He had this great idea for these exchanges and scale tax credits, individual mandate, all this and was introduced as legislation. It ended up as Romneycare and then ultimately ended up in the Affordable Care Act, and we call them the exchanges. Some people call it Obamacare. Actually, they are pretty good ideas.

And one of the things that frustrates the heck out of me is how this Administration continues to try to undermine what was originally a Republican idea, but actually has promise to provide better health care and not just lay it all on the Federal Government.

There are a couple of things that I would welcome the chance to discuss with you, and I suspect some of my colleagues would as well. And I would just lay that out there and hope that you will find time in your schedules to do that this year.

Ms. VERMA. I would be happy to visit with you anytime.

Senator CARPER. Good. Thanks so much.

Chairman JOHNSON. Thank you, Senator Carper.

Let me quickly step through my remaining questions, then, unless you want to go now.

Senator MCCASKILL. Well, no, I can go after you. It does not matter to me.

Chairman JOHNSON. Oh, no. Go right ahead.

Senator MCCASKILL. Oh, OK. I was just trying to be sure.

Naloxone prices. I asked the Assistant Secretary for Health at HHS in the Finance Committee in April to seek an explanation for the Naloxone delivery device price increases.

According to you, CMS, Medicare Part D spending per dosage unit on Evzio increased over 500 percent between 2015 and 2016. This is Kaleo Pharma.

With total spending in 2016 of over \$40 million, that could pay for a lot of those audits.

I asked them to formally seek an explanation for these price increases. Are you aware if there has been any outreach to Kaleo since April regarding the price increase for Naloxone?

Ms. VERMA. I cannot speak specifically, not necessarily from my department, but one of the things we are concerned about is making sure that we have transparency around all of these increases. It is one of the things that we took action on earlier this year, is to put out our Drug Dashboard, which provides transparency to the American public about the year-over-year increases in drug pricing. We think that is important that people have that information.

Senator MCCASKILL. Do you agree that Secretary Alex Azar would have the ability to negotiate directly with Kaleo to reduce Part D spending if he chose to do so?

Ms. VERMA. Generally, what we want to do in our strategy around drug prices, something that we are very concerned about—there is a lot of effort going on—one of the things that we want to do is strengthen competition and negotiation. We think negotiation is important. That is why we have our Part D plans essentially in that role negotiating on our behalf, and what we want to do is strengthen their negotiating position.

One of the things that we recently took action on was for Medicare Advantage plans, to give them more authority around negotiating with manufacturers for lower prices by giving them the ability to do step therapy for Part B drugs. So we think that is really important that we do everything that we can to increase the negotiating power of our Part D plans as well as Medicare Advantage plans.

Senator MCCASKILL. So they have the ability in the Part D plans to negotiate now, but the Department of Veterans Affairs gets a much better price on this drug than any of the Part D plans. What do you attribute that to? Why is the VA able to get such a better deal than all of these private plans?

Ms. VERMA. They have a limited formulary. They have one formulary, and I think our concern with Medicare directly negotiating is that that would result in a single formulary. That would decrease—

Senator MCCASKILL. Well, but maybe for opioid overdoses, I mean, we are not talking about the difference between a variety of different drugs we are talking about saving someone's life from an opioid overdose. It seems very weird to me that the VA can have this drug at a significantly lower price than Medicare Part D.

I guarantee you if I put a jury of 12 in the box and tried that case, they would say, "What is going on? Why cannot we do a single formulary price for a drug that reduces the impact of an overdose and saves lives?"

Ms. VERMA. So we want to make sure that all Americans, especially those on our Medicare program, have access to the most affordable drugs.

The issue, though, with extending what is going on in the VA to the Medicare program is that that would limit choices for seniors.

Senator MCCASKILL. Well, if you are dying of an opioid overdose, I do not think you care what brand it is. With all due respect, we

are not talking about a drug where you are deciding how you are going to treat your allergies or how you are going to treat your high blood pressure or how you are going to treat your cholesterol. We are talking about a drug that reverses a death from overdose and the notion that that has gone up, and the reason it has gone up in price is very simple. It is because there is an increased demand, and so they can raise the price. And that is what they are doing.

So I do not think the rationale for giving seniors choices frankly carries much water when we are talking about a drug like Naloxone.

Ms. VERMA. We want to make sure that our Part D plans, our Medicare Advantage plans have every negotiating tool at their disposal to make sure that seniors are getting the lowest price possible. So I agree with you on that point, but I—

Senator MCCASKILL. Well, they are not.

Ms. VERMA. I also want to make sure that seniors have access to a variety of medications and that they can choose the plan that works best for them. I think that is important that all Americans have choice about their health care.

Senator MCCASKILL. Sometimes an exception to the rule makes the rule frankly a better rule, and I would think Naloxone, with what is going on in this country right now, how many people are dying—I do not know how many families you have talked to, but in my job, it has been heartbreaking to talk to these families. And the notion that someone cannot get Naloxone because we are worried about choices for seniors and the Part D program and all the private companies, whereas we know we could drive a lower price because the VA has, that is what is really frustrating.

Ms. VERMA. Well, I agree with you, and the opioid epidemic has been devastating. I know I have attended a funeral for a young man, so I have been personally impacted by this. And I certainly understand the anguish that many American families are going through.

I will note that in the Medicare program, these drugs are available, and we agree with you. And that is why we are working toward strengthening the negotiating position to make sure that Americans, especially our seniors, have access to these drugs at an affordable price and that they have choices about the types of plans that they pick, that it is going to work well for them and their families.

Senator MCCASKILL. Well, I just know what I would do if I was Secretary Azar and if I were you. I would say, “There is a lot of reasons for us to leave negotiating to these private plans that you can justify. I just do not know how you guys justify day in and day out the kind of price increase for this particular drug, particularly compared to another government entity that has done much better.”

Mandatory reporting of fraud, waste, and abuse. In November 2017, GAO issued a report that said CMS may have an incomplete view of the opioid-related risk in Medicare Part D because it does not require the plan sponsors to report over-prescription, waste, fraud, or abuse in this area.

As a result, CMS, quote, “is unable to determine whether its related oversight efforts are effective or should be adjusted.”

Senator Rob Portman and I reached the same conclusion in a report we released in 2016, which found that mandatory reporting of waste, fraud, and abuse could in fact help CMS monitor plan sponsors.

I asked Kim Brandt also in April of this year at the Finance Committee about the lack of reporting. She stated CMS, quote, “was exploring making that mandatory.” I pressed her to issue a rule requiring the reporting of fraud and abuse as soon as possible because this is much bigger than taxpayer dollars. This is about saving lives.

We had 644 people in my State die just in 2016, and I personally watched my mother get addicted to opioids in the end of her life through the Medicare Part D program. I had to inject myself into her myriad of doctors to make sure everyone understood that much of the pain she was complaining about was the pain of withdrawal.

What progress has CMS made about this reporting issue so that you have a better handle on the over-prescribing of opioids among the senior population?

Ms. VERMA. I think we have concurred with this recommendation, and this is something that we are looking at across the board. This will require rulemaking, and so as we go through rulemaking, we are exploring all the different options around this. But this is something that the agency is looking at, and as I said, we have concurred with the GAO recommendation around this.

Senator MCCASKILL. Well, I asked in April. It is now August. I would like some kind of report from you other than “We are looking at it” because that is what I was told in April, and people are dying every day. And a lot of those opioids are making their way into hands of others. Seniors may get them, but then others get hold of them, and the addiction starts and has a very deadly ending.

So I would like you to follow up and give me some kind of timeline as to looking at that issue.

Ms. VERMA. Sure. We will have my staff follow up with you and make sure you have updates on our progress.

Senator MCCASKILL. Thank you.

Chairman JOHNSON. Thank you, Senator McCaskill.

Administrator Verma, in your testimony on page 11,¹ you talked about intergovernmental transfers, which is why I had my staff try and find this, because you can describe these things in words, but I said I need some example where I see the dollars coming together.

This is just one of many gimmicks. Can you talk about the other gimmicks and also talk about do we have any sense of how much that is really costing the Federal Government, kind of replenishing, and if we do not have that cost, who is going to calculate it for us? Because I think it is extremely important.

I will start with Administrator Verma.

Ms. VERMA. So I agree with you. I think there are a lot of issues with intergovernmental transfers. One of the things that we are going to look at that we have put on our regulatory agenda is look-

¹ The testimony referenced by Senator Johnson appears in the Appendix on page 63.

ing at supplemental payments, and that is where we are going to take action to address some of the GAO recommendations.

But I think at large, when we are dealing with States, we need to understand where the matching dollars come from. We need to understand all of the back-end deals, how the match is being provided, and then what money goes back to the State and what money goes back to providers. I think we need to understand that, and we need to have transparency around that to make sure that those are appropriate.

Chairman JOHNSON. This will be its own separate hearing, but again, I have heard of the sales tax, which is a good little gimmick. Everybody knows about it. Again, these things are all perfectly legal, but it is a way for States to get more. So they just charge the providers a sales tax, which they basically get back, but that is a cost to Medicaid then. And it gets reimbursed from the Federal Government or gets matched by the Federal Government.

Another one is sort of the loans made to a city. So you make a million-dollar loan. They spend that on Medicaid, and then they pay that loan back when they get the match.

But this one was shocking to me. I was thinking like a million-dollar loan, \$2 million. I mean, this is literally \$122 million that the State put into it. The Federal Government puts in \$155 million. This is a State that gets more than a 50 percent match. The State gets \$271 million back out of that thing. So this is massive.

General Dodaro, do you have any idea? Do you have any idea what the volume of these gimmicks are?

Mr. DODARO. The potential for this range of gimmicks, as you are calling them, is almost limitless. I mean, the States have been very creative over the years, and as we were talking earlier about whether they are going to try to put people in the 90 percent match or the other area for individual people. That is peanuts compared to this type of cost shifting that is going on.

No one knows, and one of the recommendations we have—

Chairman JOHNSON. Has anybody ever really tried to figure it out, though?

Mr. DODARO. We have on an ad hoc basis over time, but you have to have the data. There is not accurate and complete reporting. This is one of the recommendations that we are hoping that CMS will implement—to get that information.

There is also no reason in the world why there could not be a requirement that the State auditors audit the sources and uses of the money used to support the State match for the Medicaid program, so you have an independent reporting. In my opinion, that will completely stop the gimmicks.

Chairman JOHNSON. Well, again, the gimmicks are known, and they are legal.

In this case, is not this where the State auditors—they just have a conflict of interest. I mean, they work for the State.

Mr. DODARO. Well, they are independent.

Chairman JOHNSON. Actually, you have a State Governor that—

Mr. DODARO. Yes. Well—

Chairman JOHNSON. I understand. People will shake their hand, but tell them—

Mr. DODARO. I work for the Federal Government. I am independent, and thereby, the standards that we issue the GAO, generally accepted auditing standards, they are independent. They will call it the way they see it, and we just have to give them the resources and the support, and they will do the professional and independent—

Chairman JOHNSON. OK. So you can expect a letter, and hopefully, Senator McCaskill will join this.

Mr. DODARO. All right.

Chairman JOHNSON. You are going to get a letter from me asking GAO to study this and set up the auditing guidelines to really delve into this.

Mr. DODARO. OK.

Chairman JOHNSON. With all the different types of gimmicks that we know about and how can we ferret that out and how can we get the data and how can we get the information on it.

Did you want to chime in?

Senator MCCASKILL. Well, I just think it is really important to understand that the role of State auditors is identical to the role of GAO. They are not there to take the side of—first of all, many of them are elected independently, and some of them are not. There is a few that are appointed, but most of them are elected independently. And the minute they start carrying water for their party or for defending things in their State that are a waste of taxpayer dollars, that is the end of their career. I mean, they are done.

So to look at the State auditors in the context of State spending any differently than we look at GAO in the context of Federal spending is not fair to State auditors.

Chairman JOHNSON. I am not trying to be unfair, and I am not questioning State auditors' integrity. I am just saying there is a conflict of interest there, and when all these things are legal, there is really nothing to report. That is my point, and I think we need to take a look at this and go, "OK. I know it is legal. We are not calling it fraud, but it is like the next best thing."

Mr. DODARO. Yes. But there are certain things that would be beyond the guidelines.

For example, the local government portion of this is only to be 60—it cannot be more than 60 percent of the State match. So there are some guidelines that will be exceeded if they are shifting the cost to the local government's back in a shell game that comes back to them, and then the Federal Government has to match.

Chairman JOHNSON. OK.

Mr. DODARO. CMS also has other authorities that they could impose and other requirements if they know what is going on.

In some of the cases that we found about this when we went out and audited at the State and local level, CMS was unaware of this.

So you cannot take action unless you are aware of it. So step number one is awareness with good auditing information.

Chairman JOHNSON. So we are aware, and I am going to make sure that we are even more aware.

Mr. DODARO. Right.

Chairman JOHNSON. Administrator Verma, this all gets back to data—

Ms. VERMA. Yes.

Chairman JOHNSON [continuing]. And the GAO recommendations on data. Is that something that you are also in complete agreement with and completely dedicated, and can we get your commitment to do everything we can to get the data?

Ms. VERMA. We have, and we are. On the T-MSIS system which is where—for the first time, we actually have all 50 States reporting, Puerto Rico, and DC. I can tell you that when I am looking at waivers, for example, one of the questions that I always ask my staff is, Where are they on T-MSIS? Were they, A, reporting?

Now that we have all the States reporting, my question is, What about the quality of their data? Because we think that that should be an important requirement when States are making that request.

Going back, though, to the issue about these types of arrangements and where States are getting matches from, I think that this goes to my original point. It is the structure of the program. As long as you have an open-ended entitlement, States are creating all of these types of programs to try to draw down Federal dollars, which is why we took action around the designated State health programs (DSHP). This is an example where States were saying, “We are spending money on this health care program. It is all funded by State dollars,” and CMS had allowed those States to count those dollars as matching funds. So we cut that off. We closed that loophole. That was worth about \$25 billion since 2005.

And I think, as you said, some of these things are legal, and with the State auditors, with all due respect to them, it is not clear where the incentive is. In the case of California, where CMS identified \$9.6 billion of dollars that were owed to the Federal Government, that did come from CMS.

Chairman JOHNSON. And let us face it. There are plenty of people in this town that are just happy to spend the money and send it to States too and look the other way. So we need to start with the data.

It drives me nuts. Even the spending off of that chart right there, the CBO has \$430 billion. I think your numbers are like \$395. I am an accountant. That kind of stuff drives me nuts. So we need to get the data. We need to understand the exact incentives, where the abuse is occurring. We need to report on it.

So this will be another hearing in and of itself, but a letter to you.

I think my final question really goes back to—General Dodaro, you were talking about the demonstration projects being budget-neutral. Again, the whole point of that is, hey, we got a better idea. This will be more efficient spending. So give us this waiver, and at worst, we will spend the same amount of money. At best, what we really ought to do is spend less. How far off of budget-neutral are we, or are we right back there going, “We do not know”?

Mr. DODARO. No, in some of the cases, we have quantified the amount of money, and I will provide that for the record.¹

Chairman JOHNSON. I mean, can you give me some general sense right now? Tens of billions?

Mr. DODARO. Well, it is billions. It is billions, yes.

¹ The information submitted by Mr. Dodaro appears in the Appendix on page 92.

Chairman JOHNSON. Again, none of this is in the \$37 billion improper payment.

Mr. DODARO. No. It is not in the improper payment estimate.

Chairman JOHNSON. Again, all of these things we are talking about, this is in core Medicaid right now and just people really taking advantage of the system.

Mr. DODARO. Yes, it was. For example, I just was handed a note from the team. We found almost \$1 billion in excess in Arkansas, in one State alone.

Chairman JOHNSON. Is that in 1 year or over 10?

Ms. VERMA. That was during the demonstration.

Mr. DODARO. That was during the demonstration period, so I am not sure.

Ms. VERMA. It was 5 years.

Mr. DODARO. Three-year—

Chairman JOHNSON. Five years?

Mr. DODARO. Three-year demonstration period. This is a significant amount of money. That is why we have one of the—

Chairman JOHNSON. There was a Dirksen study, a billion here, a billion there, you are talking about real bucks.

Mr. DODARO. Yes. This is significant, and I know CMS is looking at this. They are going to propose they need clarity about this.

It was the longstanding policy, but it was not being implemented and enforced. And even when there were some exceptions for some hypothetical cost situations, there was not adequate documentation as to supporting even the hypothetical cost area.

So this is an area that needs to be worked on, and I am hoping that CMS will continue to focus on this.

Ms. VERMA. And on the issue of budget neutrality, we will be taking action on that this week. So you will see those recommendations implemented.

Chairman JOHNSON. OK. Well, those are the questions I have.

Senator McCaskill, do you have any more?

Senator MCCASKILL. No.

Chairman JOHNSON. First, again, I want to thank you both. I think from my standpoint, this was just a great hearing. We had great questions from my colleagues here.

This really is just the start.

So, General Dodaro, we appreciate all the work you have already done. We will be asking you to do more.

Administrator Verma, thank you for paying attention to this stuff, and we are going to want to put more meat on the bones in terms of this program integrity, what actual actions. If we need to codify some of these things, I think we probably should, and we will have to go to other committees to do so. But the goal here is to get the data, have an ongoing production of that same data, so this does not slip back in the cracks again, and then put in place the controls that are going to survive well beyond your tenure, well beyond this Administration. We are spending way too many dollars. People need these dollars, and we cannot afford literally to waste a dollar of it.

So, again, I really do appreciate your testimony, you taking the time here. I look forward to your future involvement in our oversight work here.

And with that, the hearing record will remain open for 15 days until September 5 at 5 p.m. for the submission of statements and questions for the record.

This hearing is adjourned.

[Whereupon, at 12:12 p.m., the Committee was adjourned.]

A P P E N D I X

“Examining CMS’s Efforts to Fight Medicaid Fraud and Overpayments” Opening Statement of Chairman Ron Johnson August 21, 2018

Good morning and welcome.

This is our second hearing in recent weeks on Medicaid fraud and overpayments. Most agree that the billions of federal dollars wasted through Medicaid fraud and overpayments is a problem—the accelerating growth of Medicaid only makes the problem more pressing. As a businessman from a manufacturing background, I believe that the first step in the problem-solving process is to properly define the problem. That was the purpose of our first hearing. Today, we meet to discuss potential solutions.

As we discussed in our June hearing, the nation’s healthcare financing system is broken and is increasingly dependent on the government. With overall health spending now 17 percent of gross domestic product, the government’s share of health care spending has more than doubled since 1960.

Much of this unsustainable growth is due to Medicaid. While Medicaid is a valuable program for those in need, it consumes an ever-larger portion of the federal budget. Conceived in the 1960s as a small program to help poor people cover medical bills, Medicaid enrolled just four million people in its first year. The per-enrollee cost then was \$222.

Today, Medicaid has grown into the nation’s largest health insurer, covering more than 70 million people, at a total cost of \$554 billion per year. Per enrollee, Medicaid costs are nearly \$8,000, a 3,491 percent increase since 1966. In the next seven years, the government predicts that federal Medicaid spending will increase another 96 percent, in significant part because of the Affordable Care Act’s Medicaid expansion. The expansion has cost more than even the Centers for Medicare & Medicaid Services projected.

Government watchdogs have warned CMS for 15 years about Medicaid’s vulnerability to fraud and overpayments, and the Committee has found that CMS has not taken basic steps to fix the problems. As a result, Medicaid overpayments to providers are \$37 billion per year, a 157 percent increase since 2013. Increasingly, the program is funding fraudsters whose primary goal is self-enrichment.

Today, we welcome CMS Administrator Seema Verma who is here to provide testimony regarding CMS’s new Medicaid program integrity initiatives, announced in June of this year. We also welcome back Comptroller General Gene Dodaro, who helped us to understand the problem of Medicaid fraud and overpayments. Mr. Dodaro testified in June that CMS’s new initiatives were “a good first step, but not nearly enough.” I welcome his testimony today.

We all share the same goal of making the Medicaid program more efficient and accountable to the people it was intended to help. I look forward to a valuable discussion about what CMS can do to improve Medicaid and protect federal taxpayer dollars.

U.S. Senate Homeland Security and Governmental Affairs Committee
“Examining CMS’s Efforts to Fight Medicaid Fraud and Overpayments”

August 21, 2018

Ranking Member Claire McCaskill

Opening Statement

Thank you, Mr. Chairman. Administrator Verma and Mr. Dodaro, thank you for being here today to discuss efforts to reduce improper payments in the Medicaid program.

Two months ago, we held a hearing to talk about the rate of improper payments in the Medicaid program. I said it before and I’ll say it again: This Committee has a responsibility to ensure that the Medicaid program—which provides vital health care coverage to more than 70 million Americans, regardless of pre-existing conditions—spends taxpayer dollars appropriately and efficiently. This is especially true as managed care increasingly demands a greater proportion of Medicaid dollars. Just last month, in fact, both GAO and HHS OIG published reports on continued weaknesses and program integrity risks in Medicaid managed care. Clearly, there is a need for greater transparency over how managed care organizations spend federal dollars and greater program integrity and oversight in Medicaid generally.

And importantly, there is also a need to distinguish between improper payments and outright fraud. The reality is that fraud accounts for only a portion of total improper payments in Medicaid—most of which result from provider screening and enrollment errors—and it's important as we address this problem to distinguish between beneficiary fraud and bureaucratic bungling.

But even as we discuss federal efforts to prevent fraud in the Medicaid program, we also need to talk about other factors that lead to negative health outcomes for Americans. Because the reality is that there are actions we can take right now to improve outcomes and lower the cost of federal health programs.

First, we can fight back against skyrocketing prescription drug price increases. Earlier this year, I released a report showing that the average prices of the 20 most popular brand-name drugs in the Medicare Part D program have risen at nearly 10 times the rate of inflation. And just last month, I released a second report showing that if the federal government could negotiate directly on prices for these drugs, taxpayers could save up to \$2.8 billion dollars in a single year!

Second, we can stop the overprescription of opioids. For too long, opioid manufacturers have used illegal marketing and sales techniques to expand their market share and increase dependency on powerful—and often deadly—painkillers. These companies downplayed the risk of addiction from opioid use as

part of an aggressive campaign to convince physicians to prescribe opioids. As part of this campaign, the industry co-opted patient advocacy groups and professional societies that accepted pharma money while echoing and amplifying messages favorable to opioid use. And as opioids flowed to our communities, major distributors failed to monitor drug shipments and report potential diversion to the black market.

We need to do more to ensure these perpetrators of the opioid addiction crisis are held accountable. That is why I introduced legislation to strengthen the DEA's ability to hold distributors accountable and to bring transparency to the financial connections between the advocacy community and the opioid industry. Medicare Part D spent around \$4 billion a year on opioids in 2016, and one way to lower this cost is to ensure that opioid prescriptions are written and filled because of legitimate patient need—and for no other reason.

Finally, we need to keep the consumer protections built into the Affordable Care Act. In the latest attempt to strip millions of Americans of their health insurance, Republican attorneys general—including the attorney general of my state—have gone to court to allow insurance companies to once again refuse healthcare coverage for vulnerable Americans because of their pre-existing conditions. This is decidedly NOT what the American people want. In fact, as of

2016, an estimated 27% of adults under 65—52 million people—had pre-existing conditions that would make it difficult, if not impossible, to obtain affordable healthcare coverage without the protections of the ACA. And I can tell you that when I talk about this issue in town halls in my state—even the reddest parts of my state—no one wants to go back to the fear and uncertainty of the old system.

Mr. Chairman, you and I agree on the need to lower costs in federal healthcare programs, and I'm looking forward to hearing from our witnesses on current efforts to do so in the Medicaid program. But I also believe very strongly that one surefire way not to lower costs in our healthcare system is to strip coverage from the very Americans who need it the most.

Thank you, Mr. Chairman.

STATEMENT OF

SEEMA VERMA

ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

ON

CMS'S EFFORTS TO FIGHT MEDICAID FRAUD AND OVERPAYMENTS

BEFORE THE

U.S. SENATE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL
AFFAIRS

AUGUST 21, 2018

**Statement of Seema Verma
on
“CMS’s Efforts to Fight Medicaid Fraud and Overpayments”
U.S. Senate Committee on Homeland Security and Governmental Affairs Committee
August 21, 2018**

Chairman Johnson, Ranking Member McCaskill, and members of the committee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services’ (CMS’s) efforts to improve the integrity of the Medicaid program. I am particularly appreciative of this Committee’s recent work on this issue. As the nation’s largest payer and a steward of taxpayer dollars, our most important role is to strengthen our programs so they continue to well serve the beneficiaries who rely on them. I appreciate the opportunity to update the Committee on our efforts to improve the fiscal accountability of how we manage Federal taxpayer dollars in partnership with States.

Medicaid provides healthcare for an estimated 74.6 million Americans, including many of our most vulnerable citizens, at an annual combined Federal and State cost of over \$600 billion.¹ Medicaid expenditures have grown rapidly and are consuming ever-increasing shares of State budgets. As this Committee knows, Federal spending on the program has ballooned, growing by over \$100 billion between 2013 and 2016,² and it often sits at the number one or two spot in State budgets. We have a responsibility to make sure that taxpayer dollars are spent only on those who are truly eligible.

As the GAO acknowledged in its June 27, 2018 testimony to this Committee, “the size, complexity, and diversity of Medicaid make the program particularly challenging to oversee at the Federal level.”³ The Medicaid program has been on the GAO’s “High Risk List⁴” since 2003, and many of their outstanding recommendations have gone unimplemented for years. In March 2017, when I arrived at the agency, there were 212 outstanding GAO recommendations and 373 OIG recommendations across all CMS programs. Since then, I have placed a renewed focus on

¹ Source: CMS office of Actuary

² 2016 CMS Actuarial Report <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf>

³ <https://www.hsgac.senate.gov/imo/media/doc/Testimony-Dodaro-2018-06-27.pdf>

⁴ <https://www.gao.gov/highrisk/overview>

engaging with and utilizing their expertise and implementing their recommendations quickly and in a thoughtful manner. I am happy to report that, since March 2017, we have implemented 92 GAO recommendations and 187 HHS-OIG recommendations, including 65 for the Medicaid program (18 GAO and 47 HHS-OIG). We have more work to do and we will continue to engage with the GAO and OIG. We have submitted 11 additional Medicaid recommendations to the GAO and 8 additional Medicaid recommendations to HHS-OIG for their review and closure. For example, in the spring of 2017 CMS began sharing access to the Social Security Administration's Death Master File (DMF) with States. This important step addresses a 2015 GAO recommendation⁵ and helps States identify deceased individuals who may be improperly enrolled in their Medicaid program. As CMS moves forward with our efforts to strengthen Medicaid, we will continue to rely on input from these same partners to inform our work. For example, the GAO's 2015 Fraud Risk Assessment Framework,⁶ is providing CMS with valuable guidance on how we can ingrain fraud risk assessment principles throughout the Agency to ensure that this critical work is not completed in a silo.

Since the beginning of my tenure here at CMS, my priority has been to partner with GAO, OIG and other oversight entities to deliver better outcomes for patients, and safeguard the integrity of the Medicaid program so resources are available for the vulnerable beneficiaries who rely on the program. Our vision for transforming the Medicaid program is grounded on three principles: greater flexibility, stronger accountability, and enhanced program integrity.

Providing States Flexibility to Design Their Medicaid Programs

CMS has delivered on our commitment to resetting the State-Federal partnership by offering States unprecedented flexibility to design health programs that meet the needs of their residents. We have taken action through a number of changes that make it easier than ever before for States to design innovative approaches to improving quality, lowering costs, and delivering value to our beneficiaries.

⁵ <https://www.gao.gov/products/GAO-15-313>

⁶ <https://www.gao.gov/products/GAO-15-593SP>

Recently, CMS adopted new strategies for more efficient processes for approval of State Plan Amendments (SPAs) and waiver and adjudication under Section 1915 of the Social Security Act, as well as implementing other long term process improvements.⁷ CMS also announced new procedures, effective October 1, 2018, to prevent formation of a backlog of pending SPAs in instances where CMS has not received a State response to a formal request for additional information within 90 days of issuance.

A key goal of this initiative was to develop a process improvement strategy that enhanced the efficiency of the SPA and 1915 waiver review process, reducing the administrative burden for States and, ultimately, reducing processing times. We collaborated closely with States and the National Association of Medicaid Directors (NAMd) to identify the issues that impact SPA and 1915 waiver processing and jointly developed a number of process improvement strategies, the first of which was implemented in the fourth quarter of 2017. The concerted effort by both States and CMS on process improvement and the implementation of the new strategies are beginning to result in more efficient and timely processing of SPA and 1915 waiver actions:

- Between calendar year 2016 and the first quarter of 2018, there was a 23 percent decrease in the median approval time for Medicaid SPAs.
- Eighty-four percent of Medicaid SPAs were approved within the first 90 day review period in the first quarter of 2018, a 20 percent increase over calendar year 2016.
- Between calendar year 2016 and the first quarter of 2018, median approval times for 1915(b) waivers decreased by 5 percent, 1915(c) renewal approval times decreased by 38 percent, and 1915(c) amendment approval times decreased by 54 percent.

We've approved groundbreaking Medicaid demonstration projects, including reforms to test how Medicaid can be designed to improve health outcomes and lift individuals from poverty by connecting coverage to community engagement. We are also streamlining our internal processes and breaking down regulatory barriers that force States to commit too much of their time and resources to administrative tasks rather than focusing on delivering better care. For example, earlier this year CMS proposed relieving States' from burdensome paperwork requirements

⁷ See: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib081618.pdf>

relating to duplicative monitoring of patients in managed care and fee for service.⁸ States have raised concerns over undue administrative burden associated with meeting potentially duplicative reporting requirements of a final rule CMS published in November 2015.⁹ Specifically, States with few Medicaid members enrolled in their fee-for-service program or with members that are only temporarily enrolled, and States making small reductions to fee-for-service payment rates, have urged CMS to consider whether analyzing data and monitoring access in that program is a beneficial use of State resources.

State Accountability for Outcomes

This new flexibility must be balanced by a system that holds States accountable for producing improvements in program outcomes for the people they serve, as well as appropriate Federal oversight of program integrity to protect the American taxpayers. Ultimately, States and the Federal government share mutual obligations and accountability for the integrity of the Medicaid program and the development, application, and improvement of program safeguards necessary to ensure proper and appropriate use of both Federal and State dollars. CMS is committed to achieving this balance, and that is precisely why, in June, CMS released the first ever CMS Medicaid and Children's Health Insurance Program (CHIP) Scorecard¹⁰ to increase public transparency about the programs' administration and outcomes. For too long, we have lacked transparency in the performance and outcomes of this critical program. This first version of the Scorecard includes information on selected health and program indicators such as subsets of measures from the CMS Medicaid and CHIP Child and Adult Core Sets along with Federal and State accountability measures. The Scorecard also sheds light on key questions about the scope of Medicaid and CHIP regarding enrollment, annual expenditures, and the data CMS and States are developing to support program improvement. The Scorecard will be used to track and display progress being made throughout and across the Medicaid and CHIP programs, so others can learn from the successes of high performing States. Future iterations of the Scorecard likely will allow year-to-year comparisons to help identify trends, including on measures such as quality

⁸ <https://www.federalregister.gov/documents/2018/03/23/2018-05898/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services-exemptions-for-states-with>

⁹ <https://www.federalregister.gov/documents/2015/11/02/2015-27697/medicaid-program-methods-for-assuring-access-to-covered-medicaid-services>

¹⁰ <https://www.medicaid.gov/state-overviews/scorecard/index.html>

outcomes, per-person spending, and program integrity performance. CMS envisions that Scorecard will be strengthened by the availability of more timely, accurate, and complete data collected through the Transformed Medicaid Statistical Information System (TMSIS)¹¹ as State reporting continues to improve. By using meaningful data and fostering transparency, we will see the development of best practices that lead to positive health outcomes for our most vulnerable populations.

The first version of the Scorecard includes measures voluntarily reported by States, as well as Federally reported measures in three areas: State health system performance; State administrative accountability; and Federal administrative accountability. The metrics included in the first Scorecard reflect important health issues such as well child visits, mental health conditions, children's preventive dental services, and other chronic health conditions. The Scorecard represents the first time that CMS is publishing State and Federal administrative performance metrics - which include measures like State/Federal timeliness of managed care capitation rate reviews, time from submission to approval for demonstration projects, under the authority of section 1115 of the Social Security Act (section 1115 demonstrations), and State/Federal SPA processing times.

The data offered within the Scorecard begins to offer taxpayers insights into how their dollars are being spent and the impact those dollars have on health outcomes. In future years, the Scorecard will be updated annually with new functionality and new metrics, including opioid-related and home and community based services-related quality metrics, as well as the ability to compare spending patterns. CMS will continue to work with States to encourage greater reporting across a broader set of metrics to improve consistency across States.

Enhanced Program Integrity

Oversight of the Medicaid program requires a partnership between CMS and the States. CMS plays a significant role in supporting State efforts to meet high program standards, and we have developed a strategy that prioritizes accountability and integrity protections. In June, we

¹¹ The T-MSIS data set contains: Enhanced information about beneficiary eligibility; Beneficiary and provider enrollment; Service utilization; Claims and managed care data; and Expenditure data for Medicaid and CHIP

announced a new Medicaid program integrity strategy that will bring CMS into a new era of enhancing the accountability of how we manage Federal taxpayer dollars in partnership with States.

These efforts include several new and enhanced Medicaid program integrity initiatives that this Administration believes are essential to help strengthen and preserve the foundation of the program for the millions of Americans who depend on Medicaid's safety net. These initiatives build upon our existing program integrity efforts to include stronger audits, increased beneficiary eligibility oversight, and enhanced oversight of State compliance with Federal rules.

This enhanced Medicaid program integrity strategy was developed with input from stakeholders, including clinicians, Congress, and patients. Insight and recommendations from GAO and HHS-OIG have also contributed to these efforts.

New Audits of State Beneficiary Eligibility Determinations

As part of CMS's strategy to increase program integrity, CMS has initiated new, targeted eligibility review audits and is implementing new requirements for Payment Error Rate Measurement (PERM) audits. Medicaid was created to care for the nation's most vulnerable populations – low income seniors in need, pregnant women, children, and people with disabilities. For these individuals, Medicaid is more than a safety net, it is a lifeline – one that needs to be preserved and protected for those most in need. The Patient Protection and Affordable Care Act (PPACA), however, significantly expanded Medicaid eligibility, allowing States to enroll childless, non-disabled adults with incomes below 138 percent of the poverty level. It also provided States with an enhanced Federal contribution toward this newly eligible expansion population, covering 100 percent of these costs from 2014 through 2016, 95 percent of costs in 2017, and 94 percent this year. This match rate will decline until 2020, at which point States will receive an ongoing 90 percent match for this newly eligible expansion population. This enhanced Federal match increases the need for robust Federal oversight since States receive a higher percentage match for someone who is determined to be newly eligible for Medicaid under the PPACA. In 2016, an estimated 11.2 million newly eligible adult enrollees were covered under the expanded Medicaid eligibility, and, from 2016 through 2025, Medicaid

expenditures for adults newly eligible under the PPACA are projected to amount to \$806 billion (\$741 billion paid by the Federal government).¹²

While CMS has existing controls in these areas, we are particularly concerned by findings from the OIG about State implementation of eligibility systems for the expansion group. In 2017 and 2018, the OIG raised concerns with the accuracy of three States' determinations of Medicaid eligibility for "some newly enrolled beneficiaries."¹³

CMS is taking two key actions to address these concerns. First, CMS has begun our own review of States previously found to be high risk by the OIG to examine how they are determining which groups are eligible for Medicaid benefits. These audits will include assessing the effect of Medicaid expansion and ensuring that States are appropriately claiming the enhanced match for beneficiaries. .

Second, under a CMS regulation¹⁴ published in June 2017, CMS will once again measure the current improper payment rate for the eligibility component of PERM, beginning with the FY 2019 reporting period. This measurement and reporting process is one of many tools CMS uses to identify and address areas at risk for – and factors contributing to – improper payments. It is important to remember that not all improper payments constitute fraud or result in monetary loss to the government. An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. For example, if a physician provides a legitimate service to a legitimate beneficiary but accidentally fills out the paperwork incorrectly or is missing documentation, this would be considered an improper payment.

¹² <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf>

¹³ See: <https://oig.hhs.gov/oas/reports/region9/91602023.asp> (California); <https://oig.hhs.gov/oas/reports/region2/21501015.asp> (New York); and <https://oig.hhs.gov/oas/reports/region4/41608047.asp> (Kentucky)

¹⁴ <https://www.federalregister.gov/documents/2017/07/05/2017-13710/medicaidchip-program-medicare-program-and-childrens-health-insurance-program-chip-changes-to-the>

To reduce State burden and improve review accuracy and consistency, these PERM reviews will be conducted by a Federal contractor with support from each State. Through the improper payment rate measurement, CMS identifies and classifies types of errors and shares this information with each State. States then analyze the findings to determine the root causes for improper payments and work with CMS to develop and implement effective corrective actions to safeguard taxpayer dollars.

Targeted Audits of State Managed Care Claims for Federal Match Funds and Rate Setting

Audits are central to CMS's partnership with States—not only encouraging compliance but also revealing how to improve integrity at all levels. CMS will begin auditing some States' managed care organization financial reporting based on the amount spent on clinical services and quality improvement versus administration and profit.

Most States covered newly eligible adults through managed care programs. Due to the limited historical data and experience for the newly-eligible adult Medicaid expansion population prior to 2014, developing and reviewing managed care capitation rates was more challenging than for populations of individuals traditionally eligible for Medicaid. In particular, there was uncertainty regarding assumptions for pent-up demand and the health status of new enrollees, leading to the possibility of greater utilization of services than that of other adult enrollees already covered by Medicaid.

To address the uncertainty regarding this population, some States employed risk mitigation strategies in setting their managed care rates. Under this approach, the State requires managed care plans to pay at least 85 percent of their capitation rates on health care expenditures for their enrollees. If the plan ultimately spends under 85 percent, they are required to remit the difference to the State. The State is then required to pay back the Federal portion of those costs to the Federal government. Because of the enhanced match prescribed by the ACA, 100 percent of the costs for this population was covered by the Federal government for the first three years. The Administration is aware of concerns that managed care rates resulted in significant profits for insurance companies, and is committed to reviewing these rates and is taking action when appropriate. For example, CMS initiated oversight action to ensure that the State of California

resolves a collection issue and returns a significant amount of funding owed to the Federal government related to the State's Medicaid expansion. CMS is closely monitoring the collection and verification of managed care plans' financial data. By the end of this year, we expect to have recouped roughly \$9.5 billion in rate adjustments for the period January 2014-December 2016.

As part of this new strategy, CMS will make sure claims experience used to set capitation rates actually match what plans have been reporting. Audit activities will include review of high-risk vulnerabilities identified by the GAO and OIG, as well as other behavior previously found detrimental to the Medicaid program.

Addressing the Inherited Backlog of Disallowances

With all of our program integrity efforts, our first goal is to work in partnership with States to prevent the misuse of taxpayer dollars. But from time to time, it is necessary for us to use our enforcement mechanisms to seek the return of Federal funding that has not been claimed appropriately. When the State does not voluntarily return Federal funds associated with unallowable claims, CMS can recover them by issuing a disallowance. The disallowance process consists of significant legal, financial, and policy analyses to ensure our final determination is consistent with Medicaid statute and regulations.

This Administration inherited a backlog of potential disallowances where CMS, OIG, or State oversight activities identified potentially unallowable State claims, but CMS had not yet made a formal determination to disallow. We are taking action to clear out a number of these potential disallowances that were not issued in the past. As part of these efforts, in June we issued over \$321 million in backlogged disallowances. This year, CMS has issued disallowances for such unallowable expenses as improperly claimed school based services administrative costs, improper claims made for school-based transportation services that did not meet State and Federal requirements, improper expenditures for residential habitual services, and unallowable orthodontic services. Since March 2017, we have issued over \$590 million in total disallowances. We are committed to achieving more expeditious resolution of these types of issues, as they arise, to prevent new backlogs from developing in the future, thereby ensuring Federal funds are repaid in a timely manner.

Designated State Health Programs (DSHP) Funding Phase-Out

CMS has closed off financing loopholes that some States have used to generate Federal dollars to support State programs that are historically supported with State-only dollars. Since 2005, CMS has approved a number section 1115 demonstrations that included providing Federal funding for State expenditures for designated State health programs (DSHP) that were previously funded entirely by the State, without Federal funds.

One stated purpose of Federal DSHP funding was to ensure the continuation of these beneficial State programs while the State was incurring additional expenditures for health service delivery reform or expansion of health services under the demonstration project. However, the result has been that many States are not contributing State funds toward these delivery system reform efforts. Instead, these States are primarily relying on dollars freed up by the Federal Medicaid contribution to DSHP to draw down additional Federal Medicaid matching expenditures to support delivery system reforms. For example, one State's approved DSHP includes an immunization program and tobacco use prevention that previously were funded entirely by the State, without Federal Medicaid matching funds, and do not appear integral to the State's section 1115 demonstration supporting delivery system reform.

After reviewing the practice of DSHP funding, CMS has put out guidance to States that we will no longer approve their proposals for new or renewing section 1115 demonstrations that rely on Federal matching funds for DSHP and we will work with States to phase out this financing mechanism, by the end of their existing demonstrations. Federal DSHP funding has raised oversight concerns about its consistency with the Federal-State financial partnership established under the Medicaid statute. Moreover, current demonstrations have not made a compelling case that Federal DSHP funding is a prudent Federal investment. Authority for DSHP in current demonstrations will continue until the end of the State's current demonstration period but will not be extended or renewed.

Intergovernmental Transfers

CMS has always been concerned about ensuring that States finance their share of Medicaid payments within statutory and regulatory requirements. This can be a challenging endeavor. This Administration has been studying these approaches and where necessary has denied State proposals. We are committed to continuing this effort and holding States and providers accountable. We are exploring options to make requirements more clear as well as options for the necessary review and action that should be taken against improper financing mechanisms. One major concern has been about private/public arrangements that allow transfers of ownership between such entities to allow the use of IGTs. For example, CMS has received State requests to allow supplemental payments to private nursing facilities that lease their facility license to a local government entity that then contract back with the private owner to manage and operate the facility. This happens only on paper, and day to day operations of the facility continue unchanged. Federal rules would ordinarily prohibit a private nursing facility from providing the State match responsibility through a donation to the State. But under this arrangement, States would declare that the non-Federal share of Medicaid funding would be derived from an intergovernmental transfer (IGT) from the local government entity that leased the facility's license, when in reality it originates from the private provider. Since 2017, CMS has issued 2 formal denials of such requests as we concluded there was not a permissible source of non-Federal funding. CMS also works actively with States to provide necessary guidance to States to avoid improper financing. We are also exploring avenues to examine this issue in States where this practice has been going on for a number of years dating back to before this administration.

Budget Neutrality Policies for 1115 Medicaid Demonstration Projects

In response to longstanding concerns raised by our colleagues at the GAO¹⁵, CMS expects to issue guidance to States that formalizes recent changes that CMS made to budget neutrality for demonstration project extensions, in order to strengthen fiscal accountability and prevent the Federal government's exposure to excessive expenditures under section 1115 demonstrations. CMS will provide States with a brand new monitoring tool intended to support a more standardized and timely approach for States' demonstration expenditure reporting

¹⁵ Most recently in GAO-17-312: <https://www.gao.gov/assets/690/683888.pdf>

We will also announce changes to how we expect States to calculate their baseline expenditures to more accurately reflect State spending trends, beginning January 1, 2021. CMS will not approve section 1115 demonstrations unless the project is expected to be budget neutral to the Federal government. A budget neutral demonstration project does not result in Medicaid costs to the Federal government that are greater than what the Federal government's Medicaid costs would likely have been absent the demonstration.¹⁶ The overarching goal of CMS's approach to budget neutrality is, therefore, to limit Federal fiscal exposure resulting from the use of section 1115 authority in Medicaid.

Optimizing Data

As technology advances across the health care industry, data will continue to play an increasing role in our program integrity efforts. That's why improving Medicaid and CHIP data and systems is a high priority for CMS. Through strong data and systems, CMS and States can drive toward better health outcomes and improve program integrity, performance, and financial management in Medicaid and CHIP. CMS has been working with States to implement changes to the way in which data on health services is collected by moving from the Medicaid Statistical Information System (MSIS) to the Transformed-MSIS (T-MSIS).

As of this June, all 50 States, D.C. and Puerto Rico are now for the first time submitting data on their programs to T-MSIS, and over the course of the coming months CMS will be validating the quality and completeness of the data. CMS's ongoing goal is to use advanced analytics and other innovative solutions to both improve T-MSIS data and maximize its potential for program integrity. This will allow CMS to identify instances like a beneficiary receiving more hours of treatment than hours in a day or other flags that necessitate further investigation.

¹⁶ What the federal government's Medicaid costs would likely have been absent the demonstration may also include costs that could be federally matched if the state were to amend its Medicaid state plan or obtain waivers under certain title XIX authorities. These costs may be deemed "hypothetical" if the state could otherwise have covered these costs under a state plan amendment or a waiver under section 1915 of the Act.

Conclusion

We share the Committee's commitment to protecting beneficiaries and ensuring that taxpayer dollars are spent on legitimate items and services, both of which are at the forefront of our program integrity mission. By making sure taxpayer dollars are used responsibly, Medicaid program integrity plays an important role in our shared goal of refocusing Medicaid on the nation's most vulnerable populations in order to provide a more robust level of care and a strengthened program overall.



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MEDICAID

CMS Has Taken Steps to Address Program Risks but Further Actions Needed to Strengthen Program Integrity

Statement of Gene L. Dodaro
Comptroller General of the United States

GAO Highlights

Highlights of GAO-18-587T, a testimony before the Committee on Homeland Security and Governmental Affairs, U.S. Senate.

Why GAO Did This Study

Medicaid, a joint federal-state health care program overseen by CMS, is a significant component of federal and state budgets, with total estimated expenditures of \$596 billion in fiscal year 2017. Medicaid allows significant flexibility for states to design and implement program innovations based on their unique needs. The resulting diversity of the program and its size make the program particularly challenging to oversee at the federal level. For example, in fiscal year 2017 estimated improper payments were \$36.7 billion. Further, the Medicaid program accounted for about 26 percent of the fiscal year 2017 government-wide improper payment estimate.

This testimony focuses on the (1) major risks to the integrity of the Medicaid program, and examples of actions CMS has taken to address these risks; and (2) other actions needed to strengthen oversight of the program. This testimony draws on GAO's reports issued between November 2012 and July 2018 on the Medicaid program, and information on a program integrity strategy CMS announced in June 2018.

What GAO Recommends

As a part of its body of work on Medicaid, GAO has made 86 recommendations to address shortcomings in oversight and suggested four matters for congressional consideration. CMS has generally agreed with these recommendations and has implemented 30 of them. GAO will continue to monitor implementation of the remaining recommendations.

View GAO-18-587T. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

August 21, 2018

MEDICAID

CMS Has Taken Steps to Address Program Risks but Further Actions Needed to Strengthen Program Integrity

What GAO Found

GAO's work has identified three broad areas of risk to Medicaid program integrity as it reported in its June 2018 testimony before this Committee. For today's testimony, GAO provides examples of actions taken and plans by the Centers for Medicare & Medicaid Services (CMS) to address these areas of risk, and highlights additional efforts needed to strengthen program oversight.

- 1) **Improper payments.** To reduce improper payments and ensure only eligible individuals enroll, CMS plans to resume audits of beneficiary eligibility determinations and conduct new types of audits starting in three states. However, given the growth in Medicaid managed care, which was nearly half of Medicaid spending in fiscal year 2017, additional actions are needed to ensure that managed care payments are appropriate. For example, CMS still needs to establish processes to ensure that overpayments to providers are identified and accounted for by states when setting future payment rates.
- 2) **Supplemental payments.** Supplemental payments—which totaled \$48 billion in fiscal year 2016—are payments made to providers in addition to regular, claims-based payments for specific services. Partially in response to GAO recommendations, CMS plans to issue a proposed rule in spring 2019 to establish new reporting requirements for supplemental payments. To address GAO's recommendations, the rule would need to clearly establish approval criteria and review processes to ensure these payments are economical and efficient, as well as arrange for more accurate reporting of how states are financing their share of these payments, among other things.
- 3) **Demonstrations.** Demonstrations—which made up one-third of Medicaid spending in fiscal year 2015—allow states and CMS to test new coverage and service delivery approaches. CMS recently limited states' ability to accrue unspent demonstration funds, resulting in an estimated \$63 billion in federal savings from 2016 through 2018. Additional actions by CMS, such as ensuring demonstration budget neutrality—that demonstrations do not increase federal costs—and state evaluations of demonstrations are properly conducted, could result in significant savings and better informed policy decisions.

As reported in GAO's June 2018 testimony, GAO's prior work has also identified the following fundamental actions needed to strengthen oversight.

- **Improve data.** CMS's Transformed Medicaid Statistical Information System initiative has the potential to improve program oversight, but more needs to be done to collect complete and comparable data from all states.
- **Implement a fraud-risk strategy.** CMS established the Center for Program Integrity to lead antifraud efforts and has required antifraud training for stakeholders. However, CMS still needs to conduct a fraud risk assessment and implement a risk-based antifraud strategy for Medicaid.
- **Collaborate.** Increased collaboration between the federal government and the states can help reduce improper payments. State auditors are uniquely qualified to partner with CMS in its oversight of Medicaid. CMS could help improve program integrity by providing state auditors with a substantive and ongoing role in auditing state Medicaid programs.

Chairman Johnson, Ranking Member McCaskill, and Members of the Committee:

I appreciate the opportunity to be here today along with the Administrator of the Centers for Medicare & Medicaid Services (CMS) to discuss areas of risk to the Medicaid program and efforts that can help ensure the program's fiscal integrity.¹ The Administrator and I have met on two occasions to discuss the risks facing the Medicaid program, and the senior leadership teams from our agencies meet quarterly to discuss these risks, CMS's actions to address these risks, and GAO's open recommendations. I appreciate the constructive dialogue that our agencies have established on oversight of the Medicaid program.

The federal-state Medicaid program is one of the nation's largest sources of funding for medical and health-related services. In fiscal year 2017, Medicaid covered acute health care, long-term care, and other services for over 73 million low-income and medically needy individuals. In that same year, estimated federal and state Medicaid expenditures were \$596 billion. Medicaid has been on our high-risk list since 2003, in part, because of concerns about the adequacy of fiscal oversight and the program's improper payments—including payments made for people not eligible for Medicaid and services not actually provided.² The Medicaid program accounted for 26.1 percent of the fiscal year 2017 government-wide improper payments estimate, or \$36.7 billion.³ Of the \$36.7 billion in improper payments, \$36.4 billion were overpayments and \$283 million were underpayments.

¹CMS, within the Department of Health and Human Services (HHS), oversees the Medicaid program at the federal level.

²See GAO, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, GAO-17-317 (Washington, D.C.: Feb. 15, 2017).

³See GAO, *Improper Payments: Actions and Guidance Could Help Address Issues and Inconsistencies in Estimation Processes*, GAO-18-377 (Washington, D.C.: May 31, 2018). An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, payment for services not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. See 31 U.S.C. § 3321 note. Office of Management and Budget guidance also instructs agencies to report as improper payments any payments for which insufficient or no documentation is found.

The partnership between the federal government and states is a central tenet of the Medicaid program. Within broad federal requirements, states have significant flexibility to design and implement their programs based on their unique needs, resulting in 56 distinct state Medicaid programs.⁴ These programs are administered at the state level and overseen at the federal level by CMS. The resulting variability of state Medicaid programs complicates federal efforts to oversee program payments and beneficiaries' access to services, making collaborative activities a necessary strategy to improving Medicaid oversight. It is critical that CMS and states leverage available federal and state resources, as dollars wasted detract from the program's ability to ensure that the individuals who rely on Medicaid—including low-income children and individuals who are elderly or disabled—are provided adequate care.

In my June 2018 testimony before this Committee, I laid out major risks to the integrity of the Medicaid program and actions needed to manage these risks.⁵ Today, I will provide examples of actions CMS has taken to address these major risks, and identify where additional actions are needed. Specifically, my testimony will focus on

1. major risks to the integrity of the Medicaid program, and examples of actions CMS has taken to address these risks; and
2. other actions needed to strengthen oversight of the program.

My statement is based on our large body of work examining the Medicaid program, particularly reports issued and recommendations made from November 2012 to July 2018; these reports provide further details on our scope and methodology. (A list of related reports is included at the end of this statement.) It is also based on information from CMS's June 2018 planned program integrity strategy, as well as interviews with and documents from CMS officials. We conducted all of the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable

⁴Medicaid programs are administered by the 50 states, the District of Columbia, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

⁵See GAO, *Medicaid: Actions Needed to Mitigate Billions in Improper Payments and Program Integrity Risks*, GAO-18-598T (Washington, D.C.: June 27, 2018).

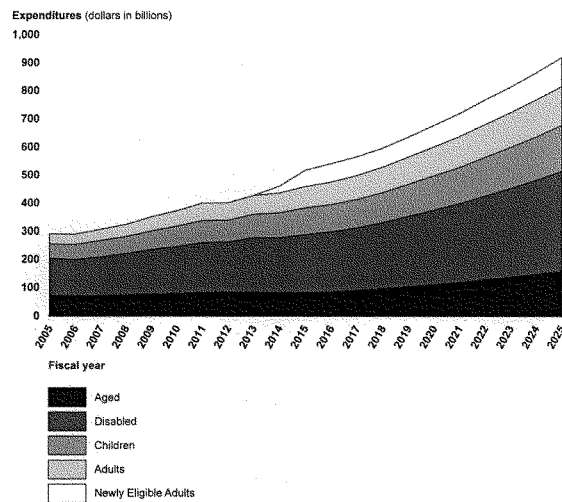
basis for our findings and conclusions based on our audit objectives. We obtained agency views on the information in this statement and have incorporated comments as appropriate.

Background

Among health care programs, Medicaid is the largest as measured by enrollment and the second largest as measured by expenditures, second only to Medicare. The CMS Office of the Actuary projected that Medicaid spending would grow at an average rate of 5.7 percent per year, from fiscal years 2016 to 2025, with projected Medicaid expenditures reaching \$958 billion by fiscal year 2025.⁶ This projected growth in expenditures reflects both expected increases in expenditures per enrollee and in levels of Medicaid enrollment. Beneficiaries with disabilities and those who are elderly constitute the highest per enrollee expenditures, which are projected to increase by almost 50 percent from fiscal year 2016 to 2025. Medicaid enrollment is also expected to grow by as many as 13.2 million newly eligible adults by 2025—as additional states may expand their Medicaid programs to cover certain low-income adults under the Patient Protection and Affordable Care Act (PPACA).⁷ (See fig. 1.)

⁶Data are from the most recently issued CMS actuarial report. See Centers for Medicare & Medicaid Services, Office of the Actuary, *2016 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2016).

⁷The Patient Protection and Affordable Care Act, enacted on March 23, 2010, permits states to expand their Medicaid programs to cover nonelderly, nonpregnant adults who are not eligible for Medicare, and whose income does not exceed 133 percent of the federal poverty level. Because of the way the limit is calculated, using what is known as an “income disregard,” the level is effectively 138 percent of the federal poverty level. Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010).

Figure 1: Growth Trends in Total Medicaid Spending by Eligibility Group

Source: GAO analysis of 2016 Actuarial Report on the Financial Outlook for Medicaid. | GAO-18-687T

Note: Data after fiscal year 2012 are projected expenditures.

Under the federal-state partnership, CMS provides oversight and technical assistance for the Medicaid program, and states are responsible for administering their respective programs' day-to-day operations—including determining eligibility, enrolling individuals and providers, and adjudicating claims—within broad federal requirements. Federal oversight includes ensuring that the design and operation of state programs meet federal requirements and that Medicaid payments are made appropriately. Joint financing of Medicaid is also a fixture of the federal-state partnership, with the federal government matching most state Medicaid expenditures using a statutory formula known as the federal medical assistance percentage, that is based, in part, on each state's per capita income in relation to the national average per capita income.

States have flexibility in determining how their Medicaid benefits are delivered. For example, states may (1) contract with managed care organizations (MCO) to provide a specific set of Medicaid-covered services to beneficiaries and pay the organizations a set amount, generally on a per beneficiary per month basis; (2) pay health care providers for each service they provide on a fee-for-service (FFS) basis; or (3) rely on a combination of both delivery systems.⁸ Managed care continues to be a growing component of the Medicaid program. In fiscal year 2017, expenditures for managed care were \$280 billion, representing almost half of total program expenditures, compared with 42 percent in fiscal year 2015. Another growing component of Medicaid spending is supplemental payments to providers—such as local government hospitals and other providers—that are in addition to the regular, claims-based payments to providers for specific services. Supplemental payments have increased over the last decade and totaled more than \$48 billion in 2016.

States also have the flexibility to innovate outside of many of Medicaid's otherwise applicable requirements through Medicaid demonstrations approved under section 1115 of the Social Security Act.⁹ These demonstrations allow states to test new approaches to coverage and to

⁸CMS has also been developing and testing a variety of value-based payment models, under which physicians and other providers are paid and responsible for the care of a beneficiary for a long period of time and accountable for the quality and efficiency of the care provided. Examples of these models include accountable care organizations—groups of physicians and other health care providers who voluntarily work together to provide coordinated care—and bundled payment models, which provide a "bundled" payment intended to cover the multiple services beneficiaries receive during an episode of care for certain health conditions, such as hip replacements, congestive heart failure, and pregnancy.

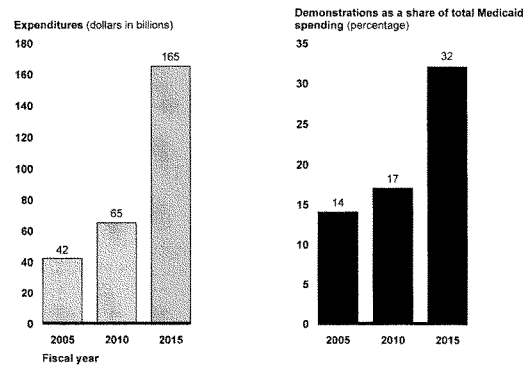
⁹Under section 1115 of the Social Security Act, the Secretary of Health and Human Services may waive certain Medicaid requirements and approve new types of expenditures that would not otherwise be eligible for federal Medicaid matching funds for experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to promote Medicaid objectives. See 42 U.S.C. § 1315(a). The Secretary has delegated the approval and administration of Medicaid section 1115 demonstrations to CMS, which requires that such demonstrations be budget neutral to the federal government; that is, the federal government should spend no more for Medicaid under a state's demonstration than it would have spent without the demonstration. There are other types of waivers that states can apply for and use, including those approved under section 1915(c) of the Social Security Act, which authorizes the Secretary of Health and Human Services to waive requirements that states provide home and community based services that they would otherwise need to meet in the absence of the waiver.

improve quality and access, or generate savings or efficiencies. For example, under demonstrations, states have

- extended coverage to certain populations,
- provided services not otherwise eligible for federal matching funds, and
- made incentive payments to providers for delivery system improvements.

As of November 2016, nearly three-quarters of states had CMS-approved demonstrations. In fiscal year 2015, total spending under demonstrations represented a third of all Medicaid spending nationwide. (See fig. 2.)

Figure 2: Total Expenditures under Medicaid Section 1115 Demonstrations, Fiscal Years 2005, 2010, and 2015



Source: GAO analysis of Centers for Medicare & Medicaid Services demonstration expenditures data. | GAO-18-687T

Additional Actions Could Enhance CMS's Efforts to Address Major Risks to the Medicaid Program

In our June 2018 testimony before this Committee, we identified three broad areas of risk to Medicaid program integrity. These risk areas are improper payments, supplemental payments, and demonstrations. CMS has taken or plans to take specific steps to address these risks, but additional actions are still needed to manage these risks and strengthen oversight of the Medicaid program, as we have recommended previously.

Improper Payments

In fiscal year 2017, the estimate of improper payments was 10.1 percent of Medicaid spending, or \$36.7 billion.¹⁰ CMS annually computes the Medicaid improper payment estimate as a weighted average of states' improper payment estimates for three component parts—fee-for-service, managed care, and beneficiary eligibility determinations. The improper payment estimate for each component is developed under its own methodology within CMS's Payment Error Rate Measurement (PERM) program, with each having different improper payment estimates and oversight concerns.

Fee-for-Service. The FFS component of improper payments measures errors in a sample of FFS claims, which are records of services provided and the amount the Medicaid program paid for these services. For the majority of sampled FFS claims, the PERM review contractor performs a medical review, which includes a review of the medical documentation to determine errors that do not meet federal and state policies, such as medically unnecessary services, diagnosis coding errors, and policy violations.¹¹

In fiscal year 2017, CMS reported a FFS improper payment estimate of 12.9 percent, or \$25 billion. CMS's analysis of improper payments in FFS notes that many claims deemed improper lacked adequate

¹⁰Since 2016, Medicaid has exceeded the 10 percent criterion set in statute by the Improper Payments Elimination and Recovery Act of 2010. When an agency is determined to not be in compliance with one or more of the Improper Payments Elimination and Recovery Act criteria by its Inspector General, it must submit a plan to Congress describing the actions it will take to come into compliance.

¹¹All FFS claims are also subject to a data processing review, which includes a verification of provider eligibility, beneficiary information, and that the payment for a covered service was accurately calculated and paid.

provider documentation, such as not having national provider identification numbers on claims.¹² Our work has also detailed concerns related to the accuracy of provider enrollment, as well as broader concerns regarding the data available to CMS to ensure proper oversight of providers.¹³ According to information provided by CMS about its June 2018 program integrity strategy, the agency plans to assist states with screening Medicaid providers, as well as conduct Medicaid provider education to reduce erroneous billing.

However, we have previously noted that without better data, CMS may not be able to identify patterns that indicate inappropriate provider billing. Our prior recommendations in this area have focused on data improvements; CMS has agreed with these recommendations and we are tracking their implementation. Our concerns about provider oversight, however, are longstanding and will require significant and consistent efforts on the part of CMS and the states. Addressing our concerns would require efforts to develop systems that can accurately track and screen providers, as well as ensure that any ineligible providers are appropriately excluded and that such exclusions are communicated across states.

Managed Care. The managed care component measures errors that occur in the payments that state Medicaid agencies make to MCOs on behalf of enrollees. The PERM assesses whether any payments made to the MCOs were in amounts different than those the state Medicaid agency is contractually required to pay, which are approved by CMS. In contrast to the FFS component, the managed care component of the PERM includes neither a medical review of services delivered to enrollees, nor reviews of MCO records or data.

In fiscal year 2017, CMS reported a managed care improper payment estimate of 0.3 percent or \$500 million, an estimate that does not

¹²Specifically, 46.6 percent of estimated Medicaid improper payments in fiscal year 2017 were caused by non-compliance with provider screening and national provider identification requirements.

¹³See GAO, *Medicaid: CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services*, GAO-17-169 (Washington, D.C.: Jan. 12, 2017) and *Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvement*, GAO-17-173 (Washington, D.C.: Jan. 6, 2017). Personal care services provide assistance to beneficiaries of all ages who have limited ability to care for themselves because of physical, developmental, or intellectual disabilities. Personal care services assist beneficiaries with activities of daily living such as bathing, dressing, and toileting.

determine whether MCO payments to providers were for services that were medically necessary, actually provided, accurately billed and delivered by eligible providers, or whether the MCO costs were allowable and appropriate. We have previously recommended that CMS take steps to mitigate the program risks that are not measured in the PERM, which could include actions such as revising the PERM methodology or focusing additional audit resources on managed care. CMS agreed with our recommendation and information on its June 2018 program integrity strategy mentions plans to check whether MCOs' reported financial statements accurately reflect the services provided. CMS plans to compare encounter claims to the services provided by MCOs. It also noted plans to implement reviews of high-risk vulnerabilities that we and the Department of Health and Human Services' (HHS) Office of the Inspector General (HHS-OIG) have identified. We will review the particulars of how CMS plans to implement these actions when they become available.

In July 2018, we reported on key payment risks in Medicaid managed care and found that, while CMS has taken some steps to improve program integrity in managed care—including strengthening regulations, and beginning to include managed care in the monitoring and auditing process—these efforts remain incomplete. For example, CMS had not developed a process to help ensure that overpayments to providers are identified by the states. We made three recommendations including that CMS ensure states account for overpayments in setting future MCO payment rates. CMS agreed with our recommendations.

Beneficiary Eligibility. The beneficiary eligibility component of improper payments measures errors in state determinations of whether enrollees meet categorical and financial criteria for receipt of benefits under the Medicaid program. The eligibility component assesses determinations for both FFS and managed care enrollees. Prior to 2014, to assess improper payments attributable to erroneous eligibility determinations, the PERM relied on state-conducted eligibility reviews that are reported to CMS. Since 2014, the beneficiary eligibility component estimate has been set at 3.1 percent. This represents \$11.3 billion of improper payments estimated for 2017.

Beginning in the 2019 reporting year, CMS plans to resume improper payment estimates for eligibility determinations, but these reviews will be performed by CMS contractors, not states. Our prior work has identified gaps in CMS's efforts to ensure that only eligible individuals

are enrolled in Medicaid, and that Medicaid expenditures for enrollees—particularly those eligible as a result of the PPACA expansion—are matched appropriately by the federal government.¹⁴ CMS concurred with these recommendations and has taken action to establish a more rigorous approach for verifying financial and nonfinancial information needed to determine Medicaid beneficiaries' eligibility.

Information on CMS's June 2018 program integrity strategy mentions plans to initiate audits of state beneficiary eligibility determinations in three states previously reviewed by the HHS-OIG (California, Kentucky and New York). These audits will include an assessment of the impact of changes to state eligibility policy as a result of Medicaid expansion; for example, CMS plans to review whether beneficiaries were found eligible for the correct Medicaid eligibility category. However, our recommendations from October 2015 remain unimplemented and—without knowing the results of the 2019 beneficiary eligibility estimates and details of CMS's actions—it remains unclear whether CMS policies and actions will improve oversight of states' eligibility determinations.

Supplemental Payments

In our June 2018 testimony before this Committee, we described several concerns related to supplemental payments, which are payments made to providers—such as local government hospitals and other providers—that are in addition to the regular, claims-based payments made to providers.¹⁵ Supplemental payments have been growing and totaled more than \$48 billion in 2016. According to CMS officials, CMS plans to take steps to address program risks associated with supplemental payments. For example, CMS officials indicated that it anticipates issuing a proposed rule in early 2019 that would establish new reporting requirements for

¹⁴See, for example, GAO, *Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds* GAO-16-53 (Washington, D.C.: Oct 16, 2015); and *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls* GAO-15-313 (Washington, D.C.: May 14, 2015).

¹⁵See, for example, GAO, *Medicaid: Federal Guidance Needed to Address Concerns about Distribution of Supplemental Payments*, GAO-16-108 (Washington, D.C.: Feb. 5, 2016); and *Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy*, GAO-15-322 (Washington, D.C.: April 10, 2015). Also, see GAO-18-596T.

supplemental payments.¹⁶ We will examine the rule, once finalized to determine the extent to which it addresses the program risks we have identified including, for example, the need for

- more complete and accurate reporting on the sources of funds states use to finance their share of Medicaid payments;
- criteria, data, and a review process to ensure that certain supplemental payments are economical and efficient; and
- written guidance clarifying CMS's policy that requires a link between the distribution of supplemental payments and the provision of Medicaid-covered services.

Demonstration Programs

Demonstration programs, which comprised about one-third of total Medicaid expenditures in 2015, can be a powerful tool for states and CMS to test new approaches to providing coverage and delivering services that could reduce costs and improve outcomes. However, our prior work has identified several concerns related to demonstrations, including the need to ensure that (1) demonstrations meet the policy requirements of budget neutrality—that is, they must not increase federal costs—and (2) evaluations are used to assess whether demonstrations are having their intended effects.¹⁷

We have also identified a number of questionable methods used to establish spending limits for demonstration programs, and CMS has taken important steps to improve oversight of spending on demonstrations and address some of the concerns we have raised. CMS policy limits demonstration spending to the costs estimated to have occurred without the demonstration. In our prior work, we identified a number of questionable methods and assumptions that CMS permitted

¹⁶See also, Office of Management and Budget, Medicaid Supplemental Payment and Accountability, Spring 2018 Unified Agenda of Regulatory and Deregulatory Actions, (CMS-2392-P), RIN 0938-AT50, see <https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201804&RIN=0938-AT50> (accessed July 27, 2018).

¹⁷See, for example, GAO, *Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures*, GAO-18-220 (Washington, D.C.: Jan 19, 2018); and *Medicaid Demonstrations: Federal Action Needed to Improve Oversight of Spending*, GAO-17-312 (Washington, D.C.: April 3, 2017). Also, see GAO-18-598T.

states to use when estimating these costs.¹⁸ Under a policy implemented in 2016, CMS restricted states' ability to accrue unspent funds—the difference between estimated costs and demonstration spending—for each year a demonstration operates, and reduced the amount of unspent funds that states can carry forward to new demonstrations. CMS estimated that this policy reduced total demonstration spending limits by \$109 billion for 2016 through 2018, the federal share of which was \$62.9 billion. This policy change reduces the effect, but does not specifically address all, of the questionable methods that we have identified regarding how CMS sets demonstration spending limits.¹⁹ Additional actions that address states' methods of estimating costs could result in significant savings. For example, as we have previously reported, CMS continues to need written guidance on the methodologies for demonstrating budget neutrality and updates to policies to reflect the actual criteria and processes CMS uses to develop and approve demonstration spending limits.²⁰

In a January 2018 report, we also raised concerns about state-led and federal evaluations of demonstration programs, particularly with regard to how results from these evaluations may inform policy decisions. We identified gaps in reported results from state-led evaluations that were due, in part, to CMS requiring final, comprehensive evaluation reports after the expiration of the demonstrations rather than at the end of each 3- to 5-year demonstration cycle. We also found that evaluations of federal demonstrations led by CMS have been limited due to data challenges and a lack of transparent reporting. We recommended that CMS (1) establish written procedures for requiring final evaluation reports at the end of each demonstration cycle, (2) issue criteria for when it will allow limited evaluations of demonstrations, and (3) establish a policy for publicly releasing findings from federal evaluations of demonstrations. In

¹⁸See, for example, GAO, *Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns*, GAO-08-87 (Washington, D.C.: Jan. 31, 2008).

¹⁹For example, CMS did not ensure budget neutrality in its approval of a demonstration that involved using premium assistance to purchase private coverage. The CMS-approved spending limit was based, in part, on hypothetical costs that were significantly higher than they would have been under the traditional Medicaid program, and CMS did not request any data to support these assumptions. See GAO, *Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns*, GAO-14-689R (Washington, D.C.: Aug. 8, 2014).

²⁰See, GAO-18-598T.

April 2018, HHS reported that CMS had begun developing and piloting procedures and criteria related to these recommendations, and we will continue to monitor CMS's progress in this area.

Improving Data, Implementing a Fraud-Risk Strategy, and Increasing Collaboration Would Further Strengthen Medicaid Oversight

Across our body of work, we have made 86 recommendations to CMS and suggested 4 matters for congressional consideration to strengthen oversight of the Medicaid program, particularly from reports issued from November 2012 through July 2018. CMS has generally agreed with these recommendations and has implemented 30 of them to date. Among the open recommendations, opportunities exist for CMS to fundamentally strengthen program oversight by improving data about Medicaid's performance, implementing a strategy to address the risk of fraud, and strengthening federal-state collaboration.

Improving data

CMS's oversight of the Medicaid program relies heavily on state-reported data on multiple aspects of the program, including expenditures and service utilization. However, our work has demonstrated how the lack of timely, accurate, and comparable data has affected CMS's ability to ensure proper payments, assess beneficiaries' access to services, and oversee states' financing strategies. As part of its efforts to address longstanding data concerns, CMS has taken steps toward developing a reliable national repository for Medicaid data, most notably the Transformed Medicaid Statistical Information System (T-MSIS). Through T-MSIS, CMS has said that

- it will collect detailed information on Medicaid beneficiaries—such as their citizenship, immigration, and disability status—as well as any expanded diagnosis and procedure codes associated with their treatments; and
- states are to report data more frequently—and in a timelier manner—than they have previously.²¹

²¹In particular, we found that the usefulness of CMS data on Medicaid is limited because of issues with completeness, accuracy, and timeliness. With regard to timeliness, we found that available data were reported up to 3 years late and were previously submitted on a quarterly basis. Under T-MSIS, data are to be electronically transmitted to CMS on a monthly basis.

Implementing the T-MSIS initiative has been a significant, multi-year effort. CMS has worked closely with states and has reached a point where all states, the District of Columbia, and Puerto Rico are reporting T-MSIS data. The T-MSIS initiative has the potential to improve CMS's ability to identify improper payments, help ensure beneficiaries' access to services, and improve program transparency, among other benefits. In addition, CMS noted as part of its June 2018 program integrity strategy that one of its priorities is to ensure that Medicaid data are accurate and complete. CMS also noted that the agency has an ongoing goal to use advanced analytics to improve Medicaid eligibility and payment data in T-MSIS and use these data for program integrity purposes.

As we reported in December 2017, CMS has made progress toward implementing T-MSIS, but more work needs to be done before the agency or states can use these data for program oversight.²² For example, we recommended in our December 2017 report that CMS take steps to expedite the use of T-MSIS data, including efforts to obtain complete and comparable data from all states. We also recommended that CMS articulate a specific plan and associated time frames for using T-MSIS data for oversight. The agency concurred with our recommendations, and has taken some steps but has not fully implemented them. For example, the agency reported in March 2018 that it has developed a database on data quality findings, which could be used to identify solutions for common problems across states. HHS stated that it has begun to develop a data quality scorecard for T-MSIS users, which aggregates data quality findings in a user-friendly tool. HHS stated that it will (1) continue to work to obtain complete T-MSIS information from all states; (2) take additional steps to share information across states on T-MSIS data limitations; and (3) implement ways for states to collaborate regarding T-MSIS. We will continue to monitor CMS's efforts to improve its data systems and their use for oversight.

Implementing a Fraud-Risk Strategy

As we reported in December 2017, CMS had taken steps to manage fraud risks facing Medicaid.²³ In that report we determined that CMS had shown commitment to combating fraud, in part, by establishing a

²²See GAO, *Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight*, GAO-18-70 (Washington, D.C.: Dec. 8, 2017).

²³GAO, *Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework*, GAO-18-88 (Washington, D.C.: Dec. 5, 2017).

dedicated entity—the Center for Program Integrity—to lead antifraud efforts, and offering and requiring antifraud training for stakeholder groups, such as providers, beneficiaries, and health insurance plans.²⁴ We identified training as a way to help CMS further create a culture of integrity and compliance, and recommended that CMS provide and require fraud-awareness training to its employees. In response to this recommendation, CMS officials stated in August 2018 that the agency has developed a training video related to fraud, and is developing annual training for all CMS employees on fraud, waste, and abuse. We will continue to monitor the implementation of this recommendation.

Additionally, in our December 2017 report, we determined that CMS had taken steps to identify some fraud risks through several control activities that target areas the agency has designated as higher risk within Medicaid. However, we found that CMS had not conducted a fraud risk assessment or designed and implemented a risk-based antifraud strategy for Medicaid. A fraud risk assessment allows managers to fully consider fraud risks to their programs, analyze their likelihood and impact, and prioritize risks. Managers can then design and implement a strategy with specific control activities to mitigate these fraud risks, as well as design and implement an appropriate evaluation. We identified a significant opportunity for CMS to organize and focus its antifraud and program integrity activities and related resources. We recommended that CMS conduct a fraud risk assessment and create an antifraud strategy for Medicaid, including an approach for evaluation. CMS concurred with our recommendations. CMS officials stated they are exploring how to apply the fraud risk framework to the Medicaid program more broadly; however, the agency has not yet implemented these recommendations.

Strengthening Federal-State Collaboration

The federal government and the states, together, play important roles in reducing improper payments and overseeing the Medicaid program. Our prior work has shown that oversight of the Medicaid program could be further improved through leveraging and coordinating program integrity efforts with state agencies, state auditors, and other partners. Given their roles and responsibilities—which can include carrying out or overseeing their state's single audits—state auditors are uniquely positioned to help

²⁴Fraud involves obtaining something of value through willful misrepresentation.

CMS in its oversight of state Medicaid programs.²⁵ Through their program integrity reviews, state auditors have identified improper payments in the Medicaid program and deficiencies in the processes used to identify them. Some examples of the state auditors' work include the following:

- In 2017, the Oregon Secretary of State Audits Division found approximately 31,300 questionable payments to Coordinated Care Organizations (which receive capitated monthly payments for beneficiaries, similar to MCOs), based on a review of 15 months of data. In addition, the state auditor found that approximately 47,600 individuals enrolled in Oregon's Medicaid program were ineligible, equating to \$88 million in avoidable expenditures.²⁶
- Massachusetts' Medicaid Audit Unit's recent annual report (covering the time period from March 15, 2017 through March 14, 2018) reported that the state auditor identified more than \$211 million in unallowable, questionable, duplicative, unauthorized, or potentially fraudulent billing in the program.²⁷
- A 2017 report released by the Louisiana Legislative Auditor's Office stated that the office reviewed Medicaid eligibility files and claims data covering January 2011 through October 2016, and found \$1.4 million in questionable duplicate payments.²⁸

²⁵Organizations based in the United States with expenditures of federal funding of \$500,000 or more (\$750,000 or more for fiscal years beginning on or after December 26, 2014) within the organization's fiscal year are required to send an audit report to the Office of Management and Budget (OMB), in accordance with the Single Audit Act, as amended, and OMB implementing guidance. See 31 U.S.C. §§ 7501-7507; 2 C.F.R., pt. 200, subpt. F. (2017) (as added by 78 Fed. Reg. 78590, 78608 (Dec. 26, 2013)). A single audit consists of (1) an audit and opinions on the fair presentation of the financial statements and the schedule of expenditures of Federal awards; (2) gaining an understanding of and testing internal control over financial reporting, and the entity's compliance with laws, regulations, and contract or grant provisions that have a direct and material effect on certain federal programs (i.e., the program requirements); and (3) an audit and an opinion on compliance with applicable program requirements for certain federal programs.

²⁶State of Oregon, Secretary of State, Dennis Richardson and Oregon Audits Division Director, Kip Memmott, *Oregon Health Authority Should Improve Efforts to Detect and Prevent Improper Medicaid Payments*, Report 2017-25 (Salem, Ore.: November 2017).

²⁷Commonwealth of Massachusetts, Office of the State Auditor Suzanne M. Bump, *Office of the State Auditor—Annual Report Medicaid Audit Unit, March 15, 2017-March 14, 2018* (Boston, Mass.: March 15, 2018).

²⁸Louisiana Legislative Auditor, State of Louisiana, *Duplicate Payments for Medicaid Recipients with Multiple Identification Numbers Louisiana Department of Health* (Baton Rouge, La.: March 29, 2017).

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- In fiscal year 2017, the Mississippi Division of Medicaid reported that it recovered more than \$8.6 million through various audits of medical claims paid to health care providers. The division also referred seven cases to the state's attorney general's office, in which the division had identified \$3.1 million in improper billing.²⁹

Many state auditors are uniquely positioned to help CMS and state Medicaid agencies identify program risks and provide additional oversight of the program. These auditors have detailed knowledge of and experience with auditing their state Medicaid programs, including managed care organizations, as well as Medicaid financial and data systems. We have made recommendations to CMS regarding improving its capacity to audit Medicaid providers and MCOs. As such, CMS could help improve program integrity by providing state auditors with a substantive and ongoing role in auditing their state Medicaid programs. We will continue to monitor CMS's efforts to strengthen its oversight of Medicaid and its progress in addressing our open recommendations.

Chairman Johnson, Ranking Member McCaskill, and Members of the Committee, this concludes my prepared statement. I would be pleased to respond to any questions you may have.

GAO Contacts and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact Carolyn L. Yocom, who may be reached at 202-512-7114 or yocomc@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include William Black (Assistant Director), Deirdre Brown, Kristin Ekelund, Mary Giffin, Leslie V. Gordon, Drew Long, Vikki Porter, Russell Voth, and Jennifer Whitworth.

²⁹Mississippi Division of Medicaid, *Medicaid Recovers \$8.6 Million in Fiscal Year 2017* (Jackson, Miss.), accessed May 29, 2018, <https://medicaid.ms.gov/medicaid-recovers-8-6-million-in-fiscal-year-2017/>.

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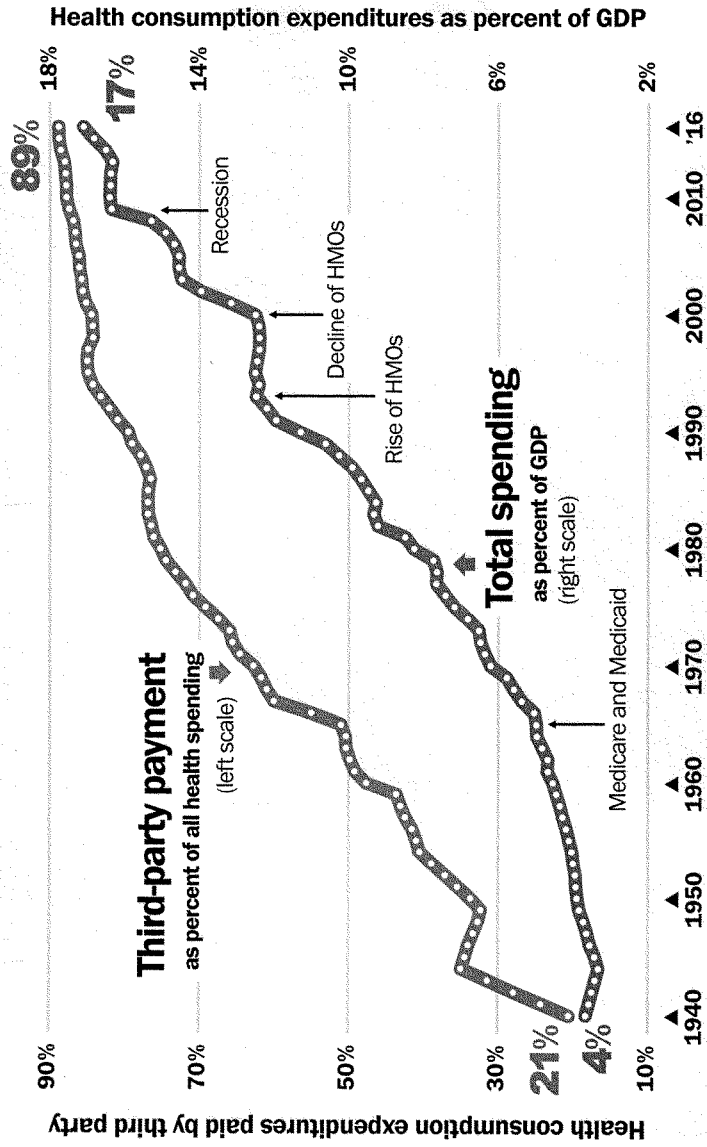
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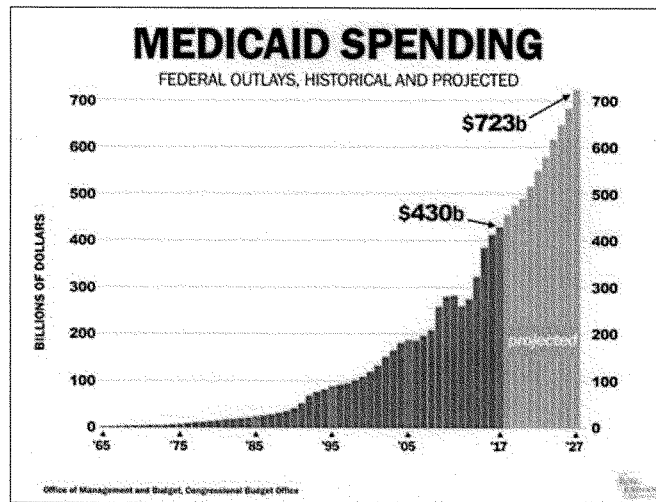
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HEALTH CARE SPENDING



CMS

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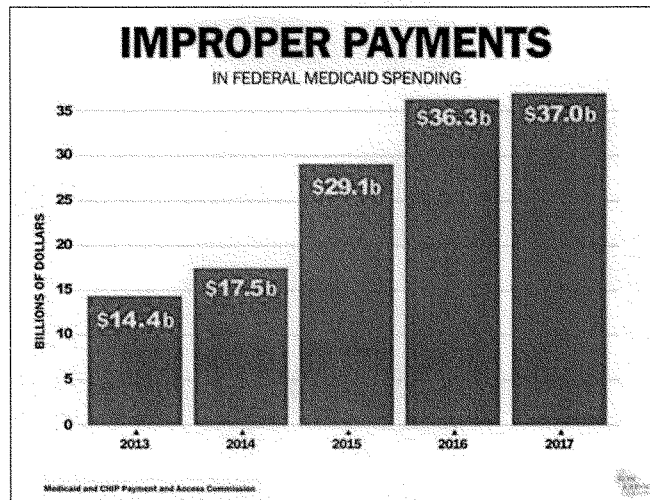
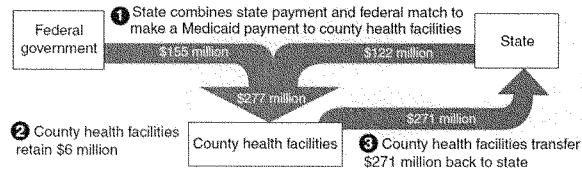


Figure 1: One State's Arrangement to Increase Federal Medicaid Payments Inappropriately



Insert A

In 2013, GAO examined 10 new demonstrations that expanded states' use of federal funds and implemented new coverage strategies. GAO found that the Department of Health and Human Services' (HHS) budget neutrality policy and process did not provide assurances that all recently approved demonstrations will be budget neutral. For 4 of 10 demonstrations GAO reviewed, GAO found that if HHS had held the 4 demonstrations' spending to levels suggested by its policy, the 5-year spending limits would have been an estimated \$32 billion lower than what was approved; the estimated federal share of this reduction would be about \$21 billion. (see [GAO-13-384](#))

Post-Hearing Questions for the Record
Submitted to the Honorable Seema Verma

“Examining CMS’s Efforts to Fight Medicaid Fraud and Overpayments”

August 21, 2018

Senator Ron Johnson

OPEN GAO RECOMMENDATIONS

You testified that implementing open recommendations from the Government Accountability Office (GAO) is a high priority and that you have placed a renewed focus on GAO recommendations regarding Medicaid, implementing 18 recommendations since March 2017.

1. GAO says that 30 of its 86 Medicaid-related recommendations since November 2012 have been closed and implemented. For each of the remaining 56 open GAO recommendations, please provide the following:

- Why CMS has not implemented the recommendation;
- What actions CMS has taken to date to implement the recommendation; and
- CMS’s estimated timetable for implementing the recommendation.

Response: At the Centers for Medicare & Medicaid Services (CMS), we appreciate the ongoing work of the Government Accountability Office (GAO) and remain closely partnered to implement and close the recommendations made to us. We have made substantial progress toward this end since my arrival at CMS and look forward to continuing the close relationship CMS has with GAO. Please see the attached Addendum A for more details about the recommendations you mentioned and whether CMS concurred.

CMS’S NEW MEDICAID PROGRAM INTEGRITY INITIATIVES

On June 26, 2018, CMS announced new program integrity initiatives for the Medicaid program. Please provide specific information about the following new initiatives:

2. For CMS’s new audits of state beneficiary eligibility determinations, please provide:
 - The timetable for completing the initial audits of California, New York, and Kentucky;
 - The methodology for the audits of California, New York, and Kentucky;
 - The audit plan and proposed questions for these audits;
 - Details on how the auditors will determine if state eligibility determinations are accurate, especially for the Medicaid expansion population;

- **The list of which states will be audited after California, New York, and Kentucky; and**
- **Information on how CMS will determine which additional states to audit.**

Response: As we announced earlier this year, CMS is initiating new audits of state beneficiary eligibility determinations in states previously reviewed by OIG. These audits include assessment of the impact of changes to state eligibility policy as a result of Medicaid expansion; for example, we will review whether beneficiaries were found eligible for the correct Medicaid eligibility category. CMS is particularly concerned about states where Medicaid enrollment for the newly eligible population was higher than initially projected. CMS contractors will be on site in New York in November, and will initiate onsite audits in Kentucky and California before February 2019. CMS plans to complete these first three audits in the spring of 2019. Following the completion of these audits and analysis of results, CMS will use our findings to inform future audits.

3. For CMS's pilot program to screen Medicaid providers on behalf of states for adverse information, such as criminal history or a history of fraud, please provide details about:

- **The number of states the pilot program will cover;**
- **The states in which the pilot program will begin; and**
- **The timetable for beginning the pilot program.**

Response: The Medicaid Program Integrity Strategy released in June 2018 includes a pilot program to screen Medicaid providers on behalf of states. Several states already use CMS' data compare service, whereby the state can submit their provider enrollment file to CMS and CMS will match the state's file with Medicare's provider enrollment file. For those providers that were already screened by Medicare, the state can rely on Medicare's screening results. As of August 2018, 24 states have used CMS' data compare service. Alabama, Arizona, California, Connecticut, Idaho, Iowa, Kansas, Louisiana, Maine, Michigan, Minnesota, Missouri, New Mexico, New Hampshire, New York, North Dakota, Ohio, Oregon, Pennsylvania, Tennessee, Texas, the District of Columbia, Vermont, and Virginia have participated thus far. CMS is working to expand this service to additional states.

In addition, in FY 2019, CMS plans to develop a pilot program that will identify a few states to begin screening Medicaid-only providers, which are those providers that are not enrolled in Medicare and for whom CMS could not previously screen. Centralizing this screening process will improve efficiency and coordination across Medicare and Medicaid while reducing the burden on states and providers.

4. For CMS's plan to educate Medicaid providers on reducing improper payments, please provide specific details about:

- **The kind of education CMS will provide;**
- **How CMS will provide the education; and**

- **Whether CMS has been educating Medicaid providers on reducing improper payments in the past.**

Response: This work will be done in two ways: CMS providing educational resources to state Medicaid agencies, and CMS providing additional educational resources that can be used by providers directly. At CMS, we will build upon existing efforts to educate providers by working with states on provider-facing tools and investments we are currently making in Medicare, including the Targeted Probe & Educate program and prior authorization. CMS will also strengthen efforts to provide effective Medicaid provider education to reduce aberrant billing, including education focused on comparative billing reports.

CMS has been working to educate Medicaid providers on reducing improper payments since the first Education Medicaid Integrity Contractor (MIC) contract was awarded in September 2008. The Education MIC has developed fraud, waste and abuse training materials to educate Medicaid providers about appropriate and accurate billing for services. Outreach and training has been delivered at in-person and webinar presentations at multiple provider association meetings across the country, and through webinars to train state staff to utilize the presentation materials with provider and beneficiary audiences. CMS also provides educational resources in various formats on the [Medicaid program integrity education website](#)¹, which provides public access to educational toolkits for promoting successful practices and enhancing awareness of Medicaid fraud, waste, and abuse.

PAYMENT ERROR RATE MEASUREMENT (PERM) AUDITS

In its June 26 announcement of new Medicaid program integrity initiatives, CMS wrote that current regulations would not allow CMS to begin issuing potential disallowances to states based on PERM program findings until 2022.

5. Is CMS considering modifying its regulations to allow for more timely disallowances?
6. Is CMS considering modifying the PERM program's rolling three-year cycle to allow for more timely audits of states?
7. You testified that doing PERM audits every year would triple the current estimated \$34 million annual cost. Other than resources, is there anything that prevents CMS from conducting PERM audits of all 50 states every year?

Response to 5-7: CMS is committed to identifying and reducing improper payments in Medicaid, and the Payment Error Rate Measurement (PERM) program is one of many tools we use to hold states accountable. CMS believes that our current approach of auditing a state through the PERM program every three years strikes an appropriate balance between minimizing administrative burden for both states and the federal government, as well as reducing costs, while still holding states accountable. It would be inefficient to measure every state every year; during

¹ <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html>

the measurement process, states use significant resources to submit data, gather necessary documentation, concur with findings or dispute errors, research underlying root causes of errors, and implement actions to prevent future errors.

It is also important to note that we are constantly working with states to give them opportunities to reduce errors by implementing corrective actions. States are required to implement Corrective Action Plans to address errors identified by the PERM program, and reviewing states every three years provides sufficient time to implement corrective actions before being reviewed again. In addition, CMS is implementing a new program that requires states to conduct pilot eligibility reviews spanning the 2-year period in between their PERM years to provide for continuous oversight of states' eligibility determinations.

STRUCTURAL CHANGES TO THE MEDICAID PROGRAM

You testified that the structure of the Affordable Care Act (ACA) Medicaid expansion creates "an incentive for states to spend more and more" and that you would support structural changes to the Medicaid program to "address the open-ended entitlement issue." You also testified that the structure of Medicaid expansion means that states do not have an incentive to focus on program integrity. Please provide specific answers to the following questions:

- 8. What changes to the Medicaid program do you believe would address the program's open-ended entitlement and decrease incentives for states to spend additional federal dollars?**
- 9. Has CMS proposed, or is it planning to propose, any structural changes to address Medicaid's open-ended entitlement? What is CMS's timetable for implementing these changes?**
- 10. What structural changes to the Medicaid program, or the ACA Medicaid expansion, do you believe would address the issue of states lacking incentives to focus on program integrity?**
- 11. Has CMS proposed, or is it planning to propose, any structural changes to the Medicaid program or the ACA Medicaid expansion to provide incentives for states to focus more on Medicaid program integrity? What is CMS's timetable for implementing these changes?**

Response to 8-11: When the federal government established the Medicaid program, it was intended to be a partnership between the federal and state governments to care for society's most vulnerable citizens with both jointly contributing towards the cost. However, that relationship has changed over the years. As long as the program remains an open-ended entitlement and there is a 90 percent match rate for the expansion population, states have an incentive to find new ways to draw down federal dollars. CMS will need to continually adapt and adjust our oversight policies. Ultimately, we need to work together to consider structural changes to the Medicaid

program that would control spending and incentivize fiscal responsibility while maintaining high quality care.

As noted in the President's FY 2019 Budget, this Administration supports giving states the flexibility they need to achieve better health outcomes for patients while putting Medicaid on a more sustainable fiscal trajectory through per capita caps or block grants beginning in FY 2020. Only when states are held accountable for a defined budget can the federal government finally end our practice of micromanaging every administrative process.

The new Medicaid program integrity strategy announced in June brings CMS into a new era of enhancing accountability of how we manage federal taxpayer dollars in partnership with states. The initiatives released in the strategy are essential to help strengthen and preserve the foundation of the program for the millions of Americans who depend on Medicaid's safety net. With historic growth in Medicaid comes an urgent federal responsibility to ensure sound fiscal stewardship and oversight of the program. These initiatives are vital steps necessary to respond to Medicaid's evolving landscape and fulfill our responsibility to beneficiaries and taxpayers. The initiatives include stronger audit functions, enhanced oversight of state contracts with private insurance companies, increased beneficiary eligibility oversight, and stricter enforcement of state compliance with federal rules.

Separately, CMS recently outlined how states must calculate budget neutrality for 1115 demonstration projects, in order to strengthen fiscal accountability. The Social Security Act authorizes Medicaid demonstrations, if they are likely to promote the objectives of Medicaid. However, CMS will only approve them if federal Medicaid spending is estimated to be "budget neutral."

Additionally, proposals in the President's FY 2019 Budget would provide additional flexibilities to states, put Medicaid on a path to fiscal stability by restructuring Medicaid financing, and refocus on the populations Medicaid was intended to serve—the elderly, people with disabilities, children, and pregnant women.

STATE MEDICAID ELIGIBILITY SYSTEMS

12. What steps is CMS taking, and planning to take, to ensure that state Medicaid eligibility systems are working properly, especially for the expansion population? What is CMS's timetable for implementing these steps?

Response: While CMS has existing eligibility controls, we are particularly concerned by findings from the OIG about State implementation of eligibility systems for the expansion group. In 2017 and 2018, the OIG raised concerns with the accuracy of three States' determinations of Medicaid eligibility for "some newly enrolled beneficiaries."

CMS is taking two key actions to address these concerns. First, CMS has begun our own review of States previously found to be high risk by the OIG to examine how they are determining which groups are eligible for Medicaid benefits. These audits will include assessing the effect of

Medicaid expansion and ensuring that States are appropriately claiming the enhanced match for beneficiaries.

Second, under a CMS regulation published in July 2017, CMS will once again measure the current improper payment rate for the eligibility component of the Payment Error Rate Measurement (PERM) program, beginning with the FY 2019 reporting period. This measurement and reporting process is one of many tools CMS uses to identify and address areas at risk for – and factors contributing to – improper payments. It is important to remember that not all improper payments constitute fraud or result in monetary loss to the government. An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. For example, if a physician provides a legitimate service to a legitimate beneficiary but accidentally fills out the paperwork incorrectly or is missing documentation, this would be considered an improper payment.

TRANSFORMED MEDICAID STATISTICAL INFORMATION SYSTEM (T-MSIS) DATA

Comptroller General Gene Dodaro testified that CMS could report regularly to Congress on the quality of the T-MSIS Medicaid data that all 50 states are now submitting.

13. Will CMS commit to providing regular updates to the Committee on the quality of T-MSIS data, and how it is being used to ensure Medicaid program integrity and fight fraud?

Response: Yes, CMS will be happy to provide the Committee with updates on T-MSIS. As of this June, all 50 States, D.C. and Puerto Rico are now for the first time submitting data on their programs to T-MSIS, and over the course of the coming months CMS will continue to validate the quality and completeness of the data. Toward that end, CMS is working closely with states on 12 top priority items to improve data quality including managed care encounter data, eligibility group coding and duplicate claims. CMS's goal is to use advanced analytics and other innovative solutions for ongoing program integrity work and we look forward to sharing our progress with you.

WORKING WITH STATE AUDITORS

Comptroller General Dodaro testified about the importance of CMS working with state auditors to root out Medicaid fraud and waste.

14. What is CMS's plan for expanding its work with state auditors to better address Medicaid program integrity issues and fight fraud?

15. Do CMS's new program integrity initiatives announced on June 26 include a mechanism for including state auditors in efforts to strengthen Medicaid program integrity?

Response to 14-15: CMS is always looking for ways to improve our programs, including ways to optimize resources and utilize the knowledge of our state and private partners. State auditors are important partners in our efforts to identify fraud, waste and abuse at the state level. CMS has met with several state auditors and looks forward to continuing to work with them as we seek to reduce the Medicaid improper payment rate and recover improperly spent taxpayer funds. We will continue to look for opportunities to identify areas where state auditors can augment our existing efforts and help us in achieving this goal.

CMS undertakes a wide array of activities to oversee and support states' Medicaid program integrity efforts. These efforts include ongoing program monitoring, state program integrity focused reviews, desk reviews, and the provision of state training and technical assistance. In addition, collaborative audits conducted by Unified Program Integrity Contractors allow CMS and the states to discuss and agree upon potential audit targets while utilizing state data. Collaborative audits have proven to be an effective way to augment states' own audit capacities by leveraging CMS resources, resulting in more timely and accurate audits.

COMMUNICATING WITH THE COMMITTEE

16. You testified that you would provide "ongoing and consistent reports" to the Committee about CMS's efforts to fight waste, fraud and abuse. Please provide specific details of how you will provide consistent reports to the Committee, including the schedule and substance of the reports.

Response: We are happy to keep the Committee informed on the progress and findings of our new program integrity initiatives as they become available. Every year, the Department of Health and Human Services partners with the Department of Justice to issue a report² detailing progress made through the Health Care Fraud and Abuse Control (HCFAC) Program, a program established to combat fraud, waste, and abuse in healthcare. As always, we will continue to update the Committee of any developments and stand ready to provide the information you need to perform the important role of Congressional oversight.

MEDICAID FRAUD INVOLVING OPIOIDS

17. On January 17, 2018, the Committee issued a majority staff report that found that the Medicaid program may be inadvertently helping to fuel the nation's opioid epidemic. In a letter the same day, Chairman Johnson asked CMS to provide information about steps it is taking to address Medicaid's role in the opioid epidemic. What steps has CMS taken to improve the structure of the Medicaid program to limit the perverse incentives that lead to opioid abuse?

² <https://oig.hhs.gov/publications/docs/hcfac/FY2017-hcfac.pdf>

Response: Confronting the opioid abuse epidemic is a top priority for this Administration. As part of the Administration's efforts, last year, CMS announced a new policy to allow states to design demonstration projects that increase access to treatment for opioid use disorder and other substance use disorders as part of a state's comprehensive substance abuse/opioid strategy. This new demonstration policy comes as a direct result of the President's commitment to address the opioid crisis and ensure states have immediate relief and flexibility. CMS has worked with seven new states since October 2017 to approve Medicaid waivers to tackle the opioid epidemic in their state. With each state having a unique population, we recognize the challenges that states face in creating programs to help, and we are committed to providing the support necessary to help states achieve positive results for their populations.

Previous policies put onerous requirements on states that ultimately prevented individuals from accessing these needed services. CMS is now offering a more flexible, streamlined approach to accelerate states' ability to respond to the national opioid crisis while enhancing states' monitoring and reporting of the impact of any changes implemented through these demonstrations. The Trump Administration's approach reflects the pressing nature of the issues states are facing on the ground.

Senator Claire McCaskill

PRE-EXISTING CONDITIONS – OVERALL IMPACT

Reforms in the Affordable Care Act (ACA) eliminated annual and lifetime caps, required free preventive services, guaranteed coverage of maternity care, and allowed children to stay on their parents' insurance until age 26. Most importantly, for the first time, the ACA required insurance companies to provide health insurance to everyone, regardless of their medical conditions and these companies could not charge higher premiums because of an individual's health status.

Unfortunately, there is litigation in the courts right now that, if successful, would return us to a health care system in which anyone can be denied coverage for the medical care they need most. A group of Republican attorneys general have challenged the constitutionality of the ACA, and the Department of Justice has refused to defend key provisions of the law.

1. If the litigation succeeds in challenging the constitutionality of the ACA, and the protections for individuals with pre-existing conditions are eliminated as a result, what impact will this have on the roughly 130 million adults living with pre-existing conditions?
2. Allowing insurance companies to again discriminate on the basis of pre-existing conditions would wreak havoc on our healthcare system. Did anyone from the Centers for Medicare and Medicaid Services (CMS) or anyone at the Department of Health and Human Services (HHS) brief DOJ on the consequences of this move for people with pre-existing conditions?

Response to 1-2: I believe it is very important that people who have pre-existing conditions have the appropriate protections in place, so that they can access the coverage that they need. If the law changes, we are committed to working with Congress to make sure the appropriate protections are in place. As you are aware, Texas and 19 other states filed a lawsuit on February 26, 2018 in the U.S. District Court for the Northern District of Texas. On December 14, 2018, the Court granted partial summary judgment to the plaintiffs in that case, declaring the entire ACA invalid. The decision is not a final decision and further briefing on the remaining issues in the case has been ordered by the court, including issues relating to appeal. Because the concerns you raise relate to issues that are currently part of this ongoing litigation, I regret that I cannot comment further. If you have any additional questions on this matter, please contact the Department of Justice.

Earlier this month, the Administration issued a final rule reversing restrictions on short-term health coverage plans. This means that, starting in October, insurers will be allowed to sell short-term plans for up to 12 months instead of the three month term allowed under federal regulations. These plans are not required to comply with the ACA regulations and do not meet minimal essential coverage standards under the law. Under this rule, insurers will once again be able to enroll people in skimpier policies that do not provide any meaningful health coverage.

The Urban Institute found that “the introduction of expanded short-term, limited-duration policies, consistent with proposed regulations, would increase the number of people without minimum essential coverage by 2.5 million in 2019. Of the 36.9 million people without minimum essential coverage, 32.6 million would have no coverage at all (completely uninsured), and 4.2 million would enroll in expanded short-term limited-duration plans.”

3. Why is CMS rolling back regulations to allow insurers to offer skimpy health insurance plans that ultimately provide very little coverage for enrollees and drive up premiums for individuals with long-term health insurance?

Response: The Patient Protection and Affordable Care Act (PPACA) is not working for far too many Americans. Average individual market premiums for plans sold using HealthCare.gov have more than doubled from 2013, the year the main PPACA regulations were implemented, through 2017. These extremely high premiums are shutting out middle-class Americans, particularly those in-between jobs or who do not qualify for subsidies. Between 2016 and 2017, enrollment among those without subsidies on the Exchange dropped 20 percent, and the decline exceeded 40 percent in some states.

While not for everyone, short-term, Limited-Duration Insurance (STLDI) plans provide an additional, more affordable option for those Americans who have been left behind by the PPACA. They offer increased choice at a lower cost and increased financial protection for consumers who are currently uninsured or face extremely high premiums and deductibles under PPACA coverage. In addition, STLDI plans offer potentially broader access to health care providers for some consumers compared to available individual market plans, which increases both health care access and consumer choice. In the STLDI Final Rule, published on August 3,

2018, we estimated that 2019 enrollment in STLDI will increase by 600,000 in 2019. Of that total, about 200,000 are expected to be current Exchange enrollees, 300,000 are expected to be currently enrolled in off-Exchange plans, and the remaining 100,000 are expected to be new consumers who are currently uninsured. By 2028, 1.4 million people are projected to have enrolled in STLDI, which will increase the total number of people with some type of coverage by 200,000.

PRE-EXISTING CONDITIONS – GAO REPORT

We currently face a very real threat to protections in the ACA. In June, Ranking Member McCaskill asked Comptroller General Gene Dodaro about a Government Accountability Office (GAO) report issued in 2011 on application and coverage denials in the individual health insurance market. The 2011 GAO report contained information from 459 insurers operating in the individual market related to application denials for the six months prior to the enactment of the ACA. GAO also reviewed data from six states on the rates of application and coverage denials.

Generally, the report found that, prior to the ACA, an insurance company could deny a person health insurance completely based on pre-existing conditions. If a person was too sick, an insurance company could refuse to cover them. The report also found that insurance companies could discriminate against people in a different way. Companies could offer individuals a policy for limited coverage and exclude the conditions that required treatment. Individuals that received treatment for a previously-disclosed pre-existing condition could be denied reimbursement.

Finally, GAO found that a quarter of insurers had denial rates of 40% or higher and that coverage denial rates varied significantly across states—with aggregate rates of claim denials ranging from 11% to 24% across the three states that collected such data.

1. Please explain the plans CMS has implemented, if any, to protect individuals from a loss of coverage if the preexisting condition protections in the ACA are eliminated.

Response: This Administration supports solutions to ensure that individuals with pre-existing conditions have access to affordable insurance. CMS's role is to implement the law, and we will continue to do so. However, if provisions of PPACA are found to be invalid, we will work with Congress and other stakeholders to continue efforts to find alternative ways to provide access to affordable insurance for people, including for those with pre-existing conditions.

IMPROPER PAYMENTS

In June, Comptroller General Gene Dodaro testified that Medicaid has been on GAO's high-risk list since 2003, in large part because of CMS's lack of oversight over the fiscal integrity of the program and the high—and growing—rate of improper payments. CMS has

acknowledged that noncompliance with provider screening and enrollment requirements are a “driver of the Medicaid improper payment rate.”

- 1. It has been over seven years since the Medicaid provider screening and enrollment requirements took effect in March 2011. Why are states still failing to properly screen and enroll providers?**
- 3. What steps should CMS take to ensure that states comply with federal regulations requiring screening and enrollment of Medicaid providers?**

Response to 1 and 3: PPACA requires screening of Medicaid and CHIP Fee-For-Service providers, and the 21st Century Cures Act requires screening of managed care network Medicaid and CHIP providers. These requirements became effective on March 25, 2011 for Medicaid and CHIP Fee-For-Service providers and January 1, 2018 for Medicaid managed care network providers.

For several years, CMS has worked to help states meet the provider enrollment requirements. For providers that were already screened by Medicare, the state can rely on Medicare’s screening results. Several states already use CMS’s data compare service, whereby the state can submit their provider enrollment file to CMS and CMS will match the state’s file with Medicare’s provider enrollment file, and CMS is working to expand this service to additional states.

Most recently, to better help states come into compliance, CMS announced that we will pilot a process to screen Medicaid providers on behalf of states. Centralizing this process will improve efficiency and coordination across Medicare and Medicaid, reduce state and provider burden, and address one of the biggest sources of error as measured by the PERM program today.

In June, Mr. Dodaro agreed with his colleague’s assertion that, quote, “if you can screen and enroll, and ensure your providers act in good faith, you’ve managed most of the fraud. A beneficiary alone trying to commit fraud needs a complicit provider. So focusing attention on ensuring good screening and enrollment processes is critical.”

- 2. Do you agree with Mr. Dodaro that proper screening and enrollment of Medicaid providers would prevent improper payments and reduce the incidence of fraud in the Medicaid program?**

Response: While any improper payment is concerning, and CMS is taking a number of actions to reduce improper payments in Medicaid, it is important to remember that not all improper payments constitute fraud, and improper payments do not mean an item or service was not needed. As part of our robust plan for new or enhanced program integrity initiatives released in June, CMS announced that, in addition to continuing our work with states to make sure they are meeting provider enrollment requirements, we will strengthen efforts to provide effective Medicaid provider education to reduce aberrant billing, including education focused on comparative billing reports. CMS also will work with states on other provider facing tools and investments we are currently making.

In addition, to better help states come into compliance, CMS announced in June that we will pilot a process to screen Medicaid providers on behalf of states. Centralizing this process will improve efficiency and coordination across Medicare and Medicaid, reduce state and provider burden, and address one of the biggest sources of error as measured by the PERM program today.

4. What steps is CMS taking to utilize the expertise of state auditors and to work together to effectively assess and evaluate states' Medicaid program integrity?

Response 4: CMS is always looking for ways to improve our programs, including ways to optimize resources and utilize the knowledge of our state and private partners. State auditors are important partners in our efforts to identify fraud, waste and abuse at the state level. CMS has met with several state auditors and looks forward to continuing to work with them as we seek to reduce the Medicaid improper payment rate and recover improperly spent taxpayer funds. We will continue to look for opportunities to identify areas where state auditors can augment our existing efforts and help us in achieving this goal.

CMS undertakes a wide array of activities to oversee and support states' Medicaid program integrity efforts. These efforts include ongoing program monitoring, state program integrity focused reviews, desk reviews, and the provision of state training and technical assistance. In addition, collaborative audits conducted by Unified Program Integrity Contractors allow CMS and the states to discuss and agree upon potential audit targets while utilizing state data. Collaborative audits have proven to be an effective way to augment states' own audit capacities by leveraging CMS resources, resulting in more timely and accurate audits.

LACK OF TRANSPARENCY

GAO recently noted that Medicaid "allows significant flexibility for states to design and implement program innovations based on their unique needs." At the same time, however, "these innovations have grown considerably over time, lack complete and accurate reporting, and do not always ensure the efficient use of federal dollars."

CMS is responsible for overseeing state Medicaid programs, but states also have an obligation to report certain data to CMS, including encounter data from managed care organizations (MCOs).

1. Do you believe current state reporting requirements are sufficient, or are further requirements necessary?

The lack of transparency in how MCOs spend Medicaid dollars makes it difficult to measure the rate of improper payments in the managed care context accurately. This is particularly worrisome given that two-thirds of Medicaid beneficiaries are enrolled in MCOs, and this number will continue to grow.

3. What efforts, if any, is CMS undertaking to increase transparency and ensure MCOs are spending taxpayer dollars properly and efficiently?

Response to 1 and 3: Every state has different needs and challenges, and that's why CMS has offered states unprecedented flexibility to design health programs that meet the needs of their residents. This new flexibility must be balanced by a system that holds States accountable for producing improvements in program outcomes for the people they serve, as well as appropriate Federal oversight of program integrity to protect the American taxpayers. CMS is committed to achieving this balance. In June, we announced a new Medicaid program integrity strategy that will bring CMS into a new era of enhancing accountability of how we manage federal taxpayer dollars in partnership with states.

As part of our new program integrity strategy, CMS is working to optimize state-provided claims and provider data. States have worked with CMS over the last few years to modernize the way in which administrative data is collected by moving from the Medicaid Statistical Information System (MSIS) to the Transformed-MSIS (T-MSIS). T-MSIS modernizes and enhances the way states submit operational data, including encounter data, about beneficiaries, providers, claims, and encounters. It also enhances the ability to identify potential fraud and improve program efficiency. Recently, CMS released a list of top priority issues with T-MSIS post-production data quality, including the consistency of managed care plan reporting of encounter data. CMS is beginning to check for consistent reporting of this information.

Also as part of our new program integrity strategy, CMS will begin targeted audits of some states' managed care organization financial reporting. CMS will be checking to make sure claims experience actually matches what plans have been reporting. Audit activities will include review of high-risk vulnerabilities identified by the GAO and OIG, as well as other behavior previously found detrimental to the Medicaid program.

In addition, CMS' Medicaid managed care 2016 final rule describes in detail the requirements for the submission of encounter data. As part of encounter data reporting, CMS expects states to report all actual payment-related fields stipulated in the T-MSIS documentation and referenced in the Medicaid managed care regulations.

CMS can withhold matching federal funds from states that fail to collect and report data from MCOs. Prior GAO reports have found that states have not complied with their obligation to report MCO data to CMS as required by law.

2. Has CMS ever withheld any federal funding from states that failed to comply with their obligation to collect and report MCO data?

Response: CMS has recently issued a letter to State Health Officials reminding states of their obligations to submit timely, quality T-MSIS data, including Medicaid managed care encounter data, to CMS. CMS has identified 12 top priority items for post-production T-MSIS data quality all states should address. If a state cannot resolve data quality issues identified by CMS with respect to previously identified top priority items within six months, CMS will request a

corrective action plan from the state. CMS will continue to monitor the quality of states' T-MSIS submissions. **CMS announced its intention to roll back the managed care rule announced in May 2016. When is that rollback expected to take place? What impact would this rollback have on CMS's ability to collect data from MCOs?**

Response: In November 2017, CMS announced that we are working to roll back burdensome regulations that the federal government has imposed on states, focusing on modifying regulations that dictate processes but don't meaningfully contribute to improving outcomes for beneficiaries. Minimizing administrative burden is a top priority of this Administration; however, this new flexibility must be balanced by a system that holds states accountable for producing improvements in program outcomes, as well as appropriate federal oversight of program integrity to protect the American taxpayers. Critical to our efforts is making sure we are gathering meaningful data from State Medicaid Agencies and Medicaid managed care organizations that will allow us to better evaluate progress and increase transparency. CMS is committed to working with states on improving their data submissions by addressing known issues and through ongoing data integrity reviews, and we expect states to develop achievable goals and commit the necessary resources to make steady progress in improving the quality of their data submissions over reasonable timeframes.

T-MSIS

GAO, HHS OIG, and CMS have all expressed concern about the lack of complete and reliable national Medicaid data. Medicaid expenditure and utilization data does not provide CMS with sufficient information to consistently ensure that payments are proper or that beneficiaries have access to covered services.

CMS has pointed to the Transformed Medicaid Statistical Information System (T-MSIS) as its key initiative to improve Medicaid data and program oversight. Yet the T-MSIS system is not operational and CMS has not provided an official deadline for when it expects to implement the system.

1. What is the current state of the T-MSIS database? When will CMS be prepared to launch the database and grant access to states?
2. On June 26, 2018, CMS announced that "[f]or the first time, every state plus Washington, D.C. and Puerto Rico are now submitting enhanced data to CMS." Is this enhanced data the same data that will be included in the T-MSIS data?
3. What is being done with the enhanced data states are reporting now? Can CMS use it in its current form?

Response to 1-3: CMS appreciates states' continued partnership on T-MSIS, now resulting in all states, the District of Columbia, and Puerto Rico successfully in production of T-MSIS data. CMS continues to monitor ongoing monthly T-MSIS data submissions and to work with the

remaining U.S. territories and entities not yet submitting data. CMS now is shifting our T-MSIS efforts to assessing and improving the quality of T-MSIS data.

Over the course of the coming months CMS will be validating the quality and completeness of the data submitted. CMS has identified 12 Top Priority Items (TPI) for post-production data quality all states should address. In an August 10, 2018 State Health Official (SHO) letter, CMS provided guidance to states regarding expectations for Medicaid and Children's Health Insurance Program (CHIP) data and ongoing T-MSIS implementation. States should resolve any data quality item identified as a pre-production issue and implement an appropriate plan of action to address the issue. States should use a CMS provided data quality tracking tool to document their plans of action and their planned compliance dates for fixing identified data quality issues. CMS expects each state to resolve data quality issues for these items no later than six months after release of the letter. If a state cannot resolve any issue identified with respect to these 12 TPI items within the six-month timeframe, CMS will request a corrective action plan from the state. CMS will expand the data quality review from the 12 TPI items to a more comprehensive data quality approach later this year. CMS will work with states to determine the priority and the timeline for resolution of identified data quality items. States should refer to Medicaid.gov for detailed information on submitting T-MSIS data, including the data dictionary, coding information, and new information posted regarding technical and data quality priorities.

CMS offers a secure way of accessing its program data through virtual access to the CMS Virtual Research Data Center (VRDC). The CMS VRDC is a virtual research environment that provides timelier access to Medicare and Medicaid program data in a more efficient and cost effective manner. Next year we expect to release T-MSIS data through the VRDC. Researchers working in the CMS VRDC will have direct access to approved data files and be able to conduct their analysis within the CMS secure environment. They will also have the ability to download aggregated reports and results to their own personal workstation.

In June, HHS OIG affirmed that "a quality national Medicaid dataset is essential to states' and the Federal Government's ability to effectively and collaboratively administer and ensure the integrity of Medicaid." To accomplish this goal, HHS OIG recommended that CMS set a deadline for when national T-MSIS data will be available for multi-state program integrity efforts.

4. Does CMS have a specific plan and associated timeframe for using T-MSIS data for oversight efforts as GAO recommended? If not, is any such plan forthcoming, and when can we expect it?
5. With the full implementation of T-MSIS as recommended, how much of a reduction in improper payments and fraud can we expect to see?

Response to 4-5: CMS is committed to working with states on improving their data submissions by addressing known issues and through ongoing data integrity reviews. While CMS recognizes this initiative will require some flexibility in state approaches, CMS expects states to develop

achievable goals and commit the necessary resources to make steady progress in improving the quality of their data submissions over reasonable timeframes.

Ongoing availability of high-quality T-MSIS data is essential to ensure robust monitoring and oversight of Medicaid and CHIP programs, to enable evaluation of demonstrations under section 1115 of the Social Security Act (the Act) and to calculate quality measures and other metrics, including those reported through the new Medicaid and CHIP Scorecard released on June 4, 2018.

As of this June, all 50 States, D.C. and Puerto Rico are now for the first time submitting data on their programs to T-MSIS, and over the course of the coming months CMS will continue to validate the quality and completeness of the data. Toward that end, CMS is working closely with states on 12 top priority items to improve data quality including managed care encounter data, eligibility group coding and duplicate claims. CMS's goal is to use advanced analytics and other innovative solutions for ongoing program integrity work and we look forward to sharing our progress with you. Additionally, as mentioned earlier next year we expect to release T-MSIS data through the VRDC. Researchers working in the CMS VRDC will have direct access to approved data files and be able to conduct their analysis within the CMS secure environment. They will also have the ability to download aggregated reports and results to their own personal workstation.

Earlier this year, the HHS Office of Inspector General was able to utilize prescription records through T-MSIS data to analyze the opioid epidemic's impact on Medicaid beneficiaries in the State of Ohio.

IMPROVEMENTS NEEDED FOR MEDICAID MANAGED CARE

A June 2018 GAO report specifically identifies CMS's delay in publishing managed care guidance to the states as one of the gaps in program integrity oversight. Last November, you told the National Association of Medicaid Directors that CMS was "going to rollback burdensome regulations that the federal government has imposed on states [and] ... start this effort beginning with both the managed care and access rules."

1. **Given GAO's finding that lack of guidance and gaps in program integrity oversight have increased the risk of improper payments, how will CMS's anticipated "rollback" of needed guidance—that has yet to be implemented—decrease the risk of improper payments by MCOs?**

Response to 1: In November 2017, CMS announced that we are working to roll back burdensome regulations that the federal government has imposed on states, focusing on modifying regulations that dictate processes but don't meaningfully contribute to improving outcomes for beneficiaries. Minimizing administrative burden is a top priority of this Administration; however, this new flexibility must be balanced by a system that holds states accountable for producing improvements in program outcomes, as well as appropriate federal oversight of program integrity to protect the American taxpayers.

2. What steps is CMS taking to ensure accurate state payments to MCOs, accurate reporting from MCOs, and accurate state reporting of MCO data to CMS?

Response to 2: Audits are central to CMS's partnership with States—not only encouraging compliance but also revealing how to improve integrity at all levels. CMS will begin auditing some States' managed care organization financial reporting based on the amount spent on clinical services and quality improvement versus administration and profit.

Most States covered newly eligible adults through managed care programs. Due to the limited historical data and experience for the newly-eligible adult Medicaid expansion population prior to 2014, developing and reviewing managed care capitation rates was more challenging than for populations of individuals traditionally eligible for Medicaid. In particular, there was uncertainty regarding assumptions for pent-up demand and the health status of new enrollees, leading to the possibility of greater utilization of services than that of other adult enrollees already covered by Medicaid.

To address the uncertainty regarding this population, some States employed risk mitigation strategies in setting their managed care rates. Under this approach, the State requires managed care plans to pay at least 85 percent of their capitation rates on health care expenditures for their enrollees. If the plan ultimately spends under 85 percent, they are required to remit the difference to the State. The State is then required to pay back the Federal portion of those costs to the Federal government. Because of the enhanced match prescribed by the ACA, 100 percent of the costs for this population was covered by the Federal government for the first three years. The Administration is aware of concerns that managed care rates resulted in significant profits for insurance companies, and is committed to reviewing these rates and is taking action when appropriate. For example, CMS initiated oversight action to ensure that the State of California resolves a collection issue and returns a significant amount of funding owed to the Federal government related to the State's Medicaid expansion. CMS is closely monitoring the collection and verification of managed care plans' financial data. By the end of this year, we expect to have recouped roughly \$9.5 billion in rate adjustments for the period January 2014-December 2016.

As part of this new strategy, CMS will make sure claims experience used to set capitation rates actually match what plans have been reporting. Audit activities will include review of high-risk vulnerabilities identified by the GAO and OIG, as well as other behavior previously found detrimental to the Medicaid program.

The GAO report included a number of recommendations to CMS, including expedited information sharing and more rigorous state reporting requirements for overpayments.

3. Do you agree with GAO's recommendations, and if so, what is the timeline at CMS for implementing these reforms?

Response: In July 2018, the GAO released a report, "Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks" that included three recommendations for CMS. We

concurred with all three recommendations and are taking steps to implement them. For example, we are determining how best to: communicate planned guidance to stakeholders; work with states to require them to report managed care organization overpayments to providers and document how overpayments are accounted for in capitation rate setting; and use pilot audits to address challenges encountered in prior managed care audits including developing audits in states where contract language does not specifically allow for recovery of overpayments by the state.

LOWERING COSTS FOR MEDICARE BENEFICIARIES

In a speech in January 2016, the President—then a candidate—pledged that his Administration would use the purchasing power of the Medicare Part D program to save the federal government billions of dollars on prescription drugs. Yet, the prescription drug blueprint Secretary Azar announced in May 2018 failed to include proposals to allow for direct negotiation by the government on Part D drugs. This move leaves money on the table for Medicare and for American seniors.

In recent comments, however, Secretary Azar has stated that direct negotiation would save money by “denying access to certain medicines for all Medicare beneficiaries,” which would “move us toward the kind of socialized medicine systems that are notorious for poor quality and access.” Other commentators have argued that negotiation alone—without the use of a CMS formulary or price setting—would have little impact on costs.

- 1. Is there no acceptable way, in the view of the Administration, for Part D to leverage its purchasing power and directly negotiate better deals with drug makers? If so how? If not, why not?**

Response: The statute prohibits the Secretary from directly negotiating for drug prices under Medicare, but gives authority to private Part D sponsors to negotiate with manufacturers for lower drug prices. We are working to strengthen these private plans’ negotiating position by giving them the market-based tools they need to negotiate better deals with drug companies. These steps will help ensure that seniors have access to drugs at an affordable price and that they have choices about the types of plans that they can choose, which will work well for them and their families.

CMS has also taken steps to encourage the uptake of generics and promote biosimilars. An HHS July 2018 report³ found that Medicare Part D plans spend \$9 billion on brand-name drugs that have a generic alternative. Choosing generics in these situations would mean \$3 billion in total savings for Part D, including \$1.1 billion in out-of-pocket savings for patients. In response to this report, CMS issued a memo to Part D plans explaining the tools they have available and the expectation CMS has to ensure that beneficiaries get the best deal.

Similar to encouraging the uptake of generics, CMS also is looking to promote biosimilars. Many of the highest-cost medicines that Medicare pays for are biologics. Biosimilars have the

³ <https://aspe.hhs.gov/system/files/pdf/259326/DP-Multisource-Brands-in-Part-D.pdf>

potential to introduce competition and drive down costs for patients. However, right now, there are only a few biosimilars available in the U.S. – the FDA has approved 12 biosimilars, but fewer than half of these are currently marketed in the U.S.⁴ To encourage growth, CMS finalized a policy last year that established separate Part B billing codes for each biosimilar product for a given biologic. This will encourage companies to invest in bringing more biosimilars to market and will increase competition to reduce costs. In addition, CMS recently revised its regulations to establish for biosimilars a lower copay that is equivalent to the lower copay required for generic drugs for low-income subsidy beneficiaries in Part D. This will lower out-of-pocket costs for biosimilars for low-income beneficiaries, thereby removing a barrier to biosimilar use. And President Trump’s FY 2019 Budget would go even further, with a proposal to eliminate cost sharing altogether for generics and biosimilars for low-income beneficiaries.

Secretary Azar has also stated that the Administration prefers to “rely on what we know works: using the free market to negotiate for our patients.” Yet, in the free market—in the world of private insurance—PBMs and plans have greater flexibility to exclude drugs that fail to deliver results that justify their cost.

2. What reforms can CMS implement to empower plans and PBMs to drive harder bargains on drug prices for Part D?

Response: This Administration has proposed and implemented numerous reforms within Medicare Part D to improve plans’ ability to deliver affordable drug coverage for seniors and reduce their costs at the pharmacy counter. Most recently, on August 29, 2018, CMS announced that Part D plans will have new flexibility, starting in 2020, to tailor their formularies using “indication-based formulary design.” This policy is used in the private sector and allows health plans to tailor on-formulary coverage of drugs predicated on specific indications. By allowing Medicare’s prescription drug plans to cover the best drug for each patient condition, plans will have more negotiating power with drug companies, which will result in lower prices for Medicare beneficiaries.

In addition, the President’s FY 2019 Budget includes a five-part plan based upon 12 years of program experience, also included in the President’s American Patients First blueprint. Seniors would benefit from the Budget’s proposals, which are designed to better protect beneficiaries from high drug prices, give plans more tools to manage spending, and address the misaligned incentives of the Part D drug benefit structure. The proposed changes would enhance Part D plans’ negotiating power with manufacturers, encourage utilization of higher value drugs, discourage drug manufacturers’ price and rebate strategies that increase spending for both beneficiaries and the Government, and provide beneficiaries with more predictable annual drug expenses through the creation of a new out-of-pocket spending cap.

⁴ As of November 2018, FDA has approved 15 biosimilars. See <https://www.fda.gov/drugs/developmentapprovalprocess/howdrugsaredevelopedandapproved/approvalapplications/therapeuticbiologicapplications/biosimilars/ucm580432.htm>.

The Administration has also proposed loosening standards that require Part D plans to cover a minimum of two drugs per category or class and cover substantially all drugs in certain “protected classes.” Under the proposal, plans could limit coverage to only one drug per category or class and use additional tools to manage drugs in the protected classes.

According to the Kaiser Family Foundation, these changes could result in substantial savings and provide greater leverage in negotiations on price, but they could also mean that “enrollees face...greater burdens in getting access to certain medications, and more difficulty finding plans that cover all of the drugs they take.”

- 3. Please explain why restricting access to certain medications for Medicare beneficiaries is justified by the cost savings in this context, but not when Medicare has the chance to save even more money through direct negotiation.**

Response: The President’s FY 2019 Budget includes a five-part proposal that would modernize the Part D drug benefit, based upon 12 years of program experience, to improve plans’ ability to deliver affordable drug coverage for seniors and reduce their costs at the pharmacy counter. Included in this five-part plan is a proposal to increase Medicare Part D plan formulary flexibility. Under current law, Medicare Part D plans must include at least two non-therapeutically equivalent drugs from each category or class if two or more such drugs are available; the President’s Budget proposal would change Part D plan formulary standards to require a minimum of one drug per category or class rather than two. By changing the requirement to a minimum of one drug per category or class, Part D sponsors may be able to negotiate discounts in specific drug categories and classes where they previously were required to cover both available drug products. This could provide Part D sponsors with additional leverage because sponsors would not be required to add a second drug, even when more than two drugs are available in a category or class. Such negotiations could result in savings that would be passed on to the Medicare program and beneficiaries. The President’s Budget proposal, which would be similar to tools used in the private insurance market, would also expand plans’ ability to use utilization management tools for specialty drugs and drugs in protected classes to empower plans to better manage the Part D drug benefit. Overall, the proposal would result in an estimated \$5.5 billion in savings over 10 years.

It is important to note that CMS would continue to conduct oversight to ensure beneficiary access would not be negatively impacted. CMS would continue to subject each formulary to our extensive Part D formulary review, including consideration of treatment guidelines, to ensure the clinical robustness of each formulary. Moreover, well-established beneficiary protections, such as transition requirements, formulary exceptions, and appeals, help beneficiaries obtain non-formulary therapies when appropriate.

NALOXONE PRICES

As opioid-related overdoses have soared in the United States, Kaleo Pharma increased prices for its Evzio naloxone delivery device by almost 600% between 2014 and 2016—from \$690 to \$4,500 for a pack of two devices. Even though Kaleo has offered coupons to ease the impact

of co-pays, patients can still feel the effect of extreme price increases in the form of rising insurance premiums.

According to CMS, Medicare Part D spending per dosage unit on Evzio increased by over 500% between 2015 and 2016, with total 2016 spending of more than \$40 million. Last year, the President's Commission on Combating Drug Addiction and the Opioid Crisis recommended that the HHS Secretary be empowered to negotiate reduced pricing for governmental units of naloxone.

In fact, according to the Washington Post, the Department of Veterans Affairs is paying, "far, far, less" than the list price for Evzio—precisely because, quote, "the agency is legally authorized to negotiate with pharmaceutical companies."

1. **Given the extraordinary need for naloxone and the stakes of the opioid epidemic, is the Administration open to providing Secretary Azar with the authority to negotiate directly with Kaleo to reduce Part D spending on Evzio?**

Response: CMS is promoting improved access to the opioid overdose reversal drug naloxone. For example, we require that naloxone appear on all Medicare Part D formularies. In addition, Medicaid programs in a number of states include forms of naloxone on their Medicaid Preferred Drug Lists. CMS has also issued guidance to states on improving access to naloxone. States can offer training in overdose prevention and response for providers and members of the community, including family members and friends of opioid users.

CMS is always looking for ways to improve our programs, including increasing access to naloxone for beneficiaries at risk of an opioid overdose. The President's FY 2019 Budget includes several proposals aimed at lowering the price of prescriptions, including a proposal that would establish a new Medicaid demonstration authority to allow up to five states more flexibility in negotiating prices with manufacturers.

The statute prohibits the Secretary from directly negotiating for drug prices under Medicare, but gives authority to private Part D sponsors to negotiate with manufacturers for lower drug prices. We are working to strengthening these private plans' negotiating position by giving them the market-based tools they need to negotiate better deals with drug companies. These steps will help seniors have access to drugs at an affordable price and that they have choices about the types of plans that they can choose, which will work well for them and their families.

MANDATORY REPORTING OF FRAUD, WASTE, AND ABUSE

In November 2017, GAO issued a report finding, in part, that CMS may have an incomplete view of opioid-related risk in the Medicare Part D population because it does not require plan sponsors to report cases of waste, fraud, abuse, or over-prescription. As a result, CMS "is unable to determine whether its related oversight efforts...are effective or should be adjusted."

At a Finance Committee hearing in April of this year, Kim Brandt, the CMS Principal Deputy Administrator for Operations, stated that CMS “was exploring making [reporting on waste, fraud, and abuse from plan sponsors] mandatory.”

1. What progress has CMS made toward issuing a rule requiring Part D plan sponsors to report cases of waste, fraud, abuse, or over-prescription?
2. Can you provide a firm timeline for when CMS will finally impose this requirement?

Response to 1-2: As I mentioned during the hearing, CMS agrees that a mandatory reporting requirement for Parts C and D plans to report fraud and corrective actions is needed. That’s why we concurred with a similar OIG recommendation in July. This will likely require rulemaking, and we plan to work with Part C and D plans to implement mandatory reporting requirements, taking the plans’ feedback into consideration. We are happy to keep the Committee apprised of our progress as we implement these changes.

OPIOID OVERPRESCRIPTION AS A COST DRIVER

According to the HHS Office of Inspector General, one in three Medicare Part D beneficiaries received opioids in 2016, and around half a million beneficiaries received high amounts of opioids, according to OIG metrics. The taxpayer expense for the roughly 80 million opioid prescriptions in Part D amounted to \$4.1 billion—this is just one measure of the cost the opioid epidemic has imposed.

One factor driving overprescribing and skyrocketing costs to federal health programs is the concerted effort by opioid manufacturers to influence physician behavior.

In February 2018, Ranking Member McCaskill released a report showing that a handful of opioid manufacturers had donated almost \$9 million to 14 advocacy groups between 2012 and 2017. These groups, in turn, often echoed and amplified messages favorable to opioid use. To address this concern, Ranking Member McCaskill introduced the Patient Advocacy Transparency Act, which would require manufacturers to disclose their donations to these advocacy groups—just like the Physician Payments Sunshine Act requires drug-makers to disclose payments to doctors.

1. Do you agree that patient advocacy groups and professional societies have played a role in shaping a medical culture of opioid over-prescription?
2. Given the significant cost opioid over-prescription has imposed on Part D, do you support requiring disclosure of payments from manufacturers to advocacy groups?

Response to 1-2: CMS understands the magnitude and impact the opioid misuse epidemic has had on our communities, and we are committed to a comprehensive and multi-pronged strategy to combat this public health emergency. We share your interest in building greater transparency to ensure that there are no financial conflicts of interest among the opioid manufacturers and

distributors and those in the medical and patient advocacy community who are working closely with the federal government to address the public health crisis resulting from the opioid epidemic

CMS is also working to increase transparency through the Open Payments data on our website⁵. Current law requires CMS to collect and display information reported by applicable manufacturers and group purchasing organizations about the payments and other transfers of value these organizations have made to physicians and teaching hospitals. Researchers and others have used the data to study a variety of related issues, including opioids. The Open Payments data does not gather information on payments to patient advocacy groups or other supply chain participants, such as distributors.

As a payor, CMS is working to make sure providers are providing the right services to the right patients at the right time. Beneficiaries are our top priority across all of our programs, and we work hard to protect their safety and put them in the driver's seat of their care. CMS is keenly focused on three areas – preventing and reducing opioid use disorders by promoting CDC guidelines for opioid prescriptions and encouraging non-opioid pain treatments; increasing access to evidence-based treatment for opioid use disorder; and leveraging data to target prevention and treatment efforts and to support fraud, waste, and abuse detection efforts.

With Sen. Toomey, Ranking Member McCaskill also introduced the Commit to Opioid Medical Prescriber Accountability and Safety for Seniors Act. This legislation would require CMS to identify prescribers of opioids who are outliers compared to their peers and provide outreach and education on prescribing. Persistent outliers would receive greater assistance from quality contractors and could be required to enroll in Medicare.

3. Does CMS support this legislation to require outreach for physicians who consistently overprescribe opioids?

Response: CMS conducts data analysis around Medicare prescribing patterns in several ways. In 2018, CMS sent Opioid Comparative Billing Reports to, and held webinars for, prescribers that included educational information for prescribers whose opioid prescribing patterns were different as compared with their peers on both a specialty and/or national level. CMS also utilizes the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) to conduct data analysis that is shared with plan sponsors to help them identify outlier prescribers or pharmacies. For example, plans receive Quarterly Outlier Prescriber Schedule II Controlled Substances Reports, which provide a peer comparison of prescribers of Schedule II controlled substances. This report now provides a separate analysis of just opioids. Plans also receive quarterly pharmacy risk assessment reports, which contain a list of pharmacies identified by CMS as high risk and provide plan sponsors with information to initiate new investigations, conduct audits, and potentially terminate pharmacies from their network, if appropriate. CMS is happy provide you and your staff with technical assistance as you consider legislation on this subject.

⁵ <https://www.cms.gov/openpayments/>

Senator Thomas R. Carper

1. *Under the ACA, all types of birth control should be covered by health insurance plans. Unfortunately, I now hear from hundreds of women in Delaware who are concerned that they will soon lose access to contraception and other health care services that help reduce unplanned pregnancies. For example, most of the short term plans supported by this Administration don't cover critical services such as maternity care and mental health services, and fall short in their coverage of preventative care and other essential health benefits.*

What steps are CMS, HHS, and the Administration taking to ensure women don't have to worry about losing access to contraception?

Response: Short-term, Limited-Duration Insurance (STLDI) plans provide consumers with more options for affordable health coverage. STLDI plans may or may not cover contraceptives and this will vary by the plan. We encourage all consumers to assess their health coverage options before enrolling in a plan, so that they can determine whether a STLDI plan is the right fit. We are also taking steps to make sure that consumers are empowered to evaluate STLDI plans when making decisions to purchase health coverage.

2. **HHS spent almost 90 percent less on outreach and advertising for ACA-compliant health insurance plans in 2018 than in 2017. What steps are you taking to ensure that consumers know about open enrollment for ACA-compliant plans?**

Response: The Exchange, about to conduct its sixth Open Enrollment this fall, is now an established platform for individuals seeking insurance. The Exchange has grown in visibility and become more familiar to Americans seeking health insurance. The plan year 2018 Open Enrollment Period was our most cost effective and successful open enrollment to date, with approximately 8.7 million consumers either selecting or automatically re-enrolling in an Exchange plan in the 39 states that use Healthcare.gov and with consumer satisfaction at an all-time high of 90 percent. These figures also show that while CMS spent less on outreach and advertising, enrollment stayed essentially the same as the previous year.

CMS spent more than \$100 million on promotional activities during Open Enrollment for plan year 2017 (nearly double what was spent the previous year) but saw enrollments decline by 10 percent from the previous year. The advertising budget is now more consistent with advertising spending for Medicare Part D and Medicare Advantage. As a comparison, 11.8 million consumers selected or were re-enrolled in an Exchange plan during Open Enrollment 2018, while 41.3 million Americans are enrolled in Medicare Part D and another 19.1 million are enrolled in Medicare Advantage. CMS's combined advertising budget for Medicare Parts C and D is \$9.7 million.

CMS will continue to leverage the capabilities of the private sector as well to ensure our partners, such as agents and brokers, are equipped with the necessary resources to educate consumers on their coverage options.

3. *Many patients and consumers rely on comprehensive coverage provided through ACA compliant plans. In contract, many short-term plans do not even provide prescription drug coverage and nearly all of these shoddy products fail to provide maternity care.*

What are you and your agency doing to ensure that people with pre-existing conditions are well informed about the shortcomings of other insurance products like short-term plans? How are you informing consumers about the potential risks of short-term plans? What steps are you and your team at CMS taking to ensure that people who are eligible for Medicare or Medicaid are not misdirected into short-term plans?

Response: As with any plan selection, we encourage consumers to carefully review the policy terms and assess their options before selecting a plan, to ensure that the plan meets their health care needs. Additionally, we are taking steps to make sure consumers are aware of the limitations of STLDI. For example, in the STLDI Final Rule published on August 3, 2018, along with the Departments of the Treasury and the Department of Labor, HHS instituted new, more robust requirements for issuers to inform consumers about the limitations of STLDI. In addition, STLDI is not required to comply all the PPACA requirements, but remains subject to state oversight. The disclosure requirements in the August 2018 STLDI rule are in addition to any requirements imposed by respective state regulators.

4. *Before the Affordable Care Act, health insurers denied or offered severely limited coverage to Americans with pre-existing conditions. Insurers could refuse to cover or charge higher premiums based on gender, as being a woman was considered a pre-existing condition. This practice cost women about \$1 billion a year in higher premiums than men.*

Is it fair for women to be charged more for their health insurance because of their gender? Should short-term health insurance plans should have to play by the same rules as ACA-compliant health insurance plans and employer health insurance plans?

Response: Fundamentally, this administration believes in more options, not fewer, for consumers. Expanding STLDI is just part of President Trump's larger agenda to improve health-care choice and competition for Americans. By expanding access to additional, more affordable coverage options, this policy will likely increase coverage for people who cannot otherwise afford individual health insurance coverage. This policy will also reduce the number of people who are cut off from STLDI coverage prematurely and left with a gap in coverage. Consumers should not be forced to choose between unaffordable insurance and no insurance at all.

5. *According to the Urban Institute, the combined effect of eliminating the individual mandate penalties and expanding short-term insurance plans will increase 2019 ACA-compliant health insurance plan premiums by an average of 18.3 percent and more than five million Americans could lose health insurance.*

Has CMS done its own analysis of the effect of expanding short-term plans and eliminating the individual mandate on the ACA individual market? For individuals with pre-existing conditions, do short-term plans offer a guarantee of comprehensive health insurance at an affordable cost?

Response: STLDI plans are simply another option for individuals, and may be a more affordable option for those between coverage or who do not qualify for subsidies in the Exchange. Individual market plans, subject to all of the PPACA requirements, remain available in the Exchanges for consumers who wish to purchase such policies, and those with incomes between 100 and 400 percent of the federal poverty level may also be eligible for subsidies. In the STLDI Final Rule, published on August 3, 2018, along with the Department of the Treasury and the Department of Labor, HHS provided updated estimates on the impacts of the rule by the independent CMS Office of the Actuary. Based on these estimates, the total number of individuals with coverage (including those with STLDI) is expected to increase. HHS also expects premiums for unsubsidized enrollees in the Exchanges to increase by 1 percent in 2019 and by 5 percent in 2028. Individuals who choose to purchase STLDI are expected to pay a premium that is approximately half of the average unsubsidized premium in the Exchange. However, the impact on individual states will vary depending on state regulations, the current state of the individual market, and the unique demographic and other characteristics of a state's population and insurance markets.

6. *Patient groups, health insurers, hospitals, small businesses, physicians, economists, and public health experts have expressed near unanimous concerns with the consequences of eliminating protections for individuals with pre-existing conditions.*

Have you or your colleagues at CMS or HHS received any meeting requests from patient groups or health care stakeholders to discuss the consequences of rolling back preexisting condition protections?

**Have you and your colleagues taken any of these meetings?
Which groups have you and your colleagues met with?**

Please provide within the next two weeks the list of patient groups you and your colleagues have met with and the list of actions CMS and HHS will take to ensure patients with pre-existing conditions will be protected under short-term plans.

Response: CMS is committed to implementing legislation passed by Congress and signed into law, and we are vigilant about fulfilling our legal obligations. We are working within the parameters of the law and will continue to build on the significant steps already taken by the Administration to promote healthcare choice and competition and decrease costs. To that end CMS meets with a broad spectrum of stakeholders on a wide variety of issues. CMS is committed to working with all stakeholders to ensure that all Americans, including those with pre-existing conditions have access to affordable coverage.

7. *Ninety-eight percent of the hundreds of comments from health care groups on the proposed short-term rule were critical of the proposal, warning the Administration that sick patients would get hurt the most. But by the time it was finalized, few changes were made from the proposed rule.*

Did you and your colleagues at CMS and HHS discuss how to address or incorporate their suggestions before finalizing the proposal?

Response: The Administration welcomes feedback from stakeholders and considers all comments received when undertaking rulemaking. After the STLDI proposed rule was published on February 21, 2018, we received approximately 12,000 comments, some of which supported the proposed rule, and others that opposed it. Along with the Departments of the Treasury and the Department of Labor, HHS considered all the comments received and finalized the proposed rule with modifications.

8. *As a result of contractor reforms that have taken place over the past several years, local MACs are now responsible for much larger jurisdictions, and there are fewer opportunities for stakeholders to interact with the contractor medical directors who make local medical policies. As an example, a decision by one MAC could impact beneficiaries in ten states. Moreover, contractors are allowed to adopt another MAC's draft LCDs. This ability to coordinate decisions effectively transforms a local coverage determination into a national one without having followed the more rigorous national coverage determination requirements. Basic procedural fairness for patients, providers, manufacturers, and other stakeholders is often lacking in local coverage decisions.*

In light of these challenges, it is imperative that improvements are made to the LCD process to enhance openness and transparency and improve accountability. Senator Isakson and I introduced legislation to improve Medicare's Local Coverage Determination process. Ms. Verma, would you work with us to ensure that patients can benefit from medical innovation by codifying and enhancing the relevant provisions in the Medicare Program Integrity Manual such as open meetings, upfront disclosure, and the creation of a meaningful reconsideration process for reviewing LCDs outside the MAC that created them?

Response: This Administration is committed to increasing transparency across our programs, including among coverage determinations and other decisions made by our contractors. An LCD is a decision by a MAC whether to cover a particular item or service locally, on a MAC-wide basis, in accordance with Section 1862(a)(1)(A) of the Social Security Act. In addition, the Act directs the Secretary to determine if, when appropriate, consistency can be achieved among these MAC-wide LCDs.

In the 21st Century Cures Act, Congress made additional changes to the LCD process, including requiring that each MAC that develops an LCD to make available, before the effective date of the determination, information on the LCD, the supporting evidence, and the rationale for the

determination. CMS is working diligently to implement these changes, which will streamline and improve the transparency of the LCD process.

However, we are always looking to improve our programs. I appreciate the need to engage in oversight to identify and evaluate challenges associated with Medicare Administrative Contractors and LCDs more generally. CMS is always willing to provide technical assistance on legislation, and we would be happy to work with you and other Members of Congress on ways to improve our programs.

Note: Following the date of the hearing, on October 3, 2018 CMS announced changes to the way contractors decide which technologies are covered by publishing a revision to Medicare's Program Integrity Manual. The updated manual responds to Congress' requirement in the 21st Century Cures Act for more transparency in the LCD process and aims to ensure an open LCD process that meets patients' needs. The changes will clarify and simplify the process, helping to ensure that companies can get therapies and devices to patients more efficiently.

B Product Number	C Product Title	D Recommendation Text	E Status
1			
2		To ensure that SCHIP funds are spent only for authorized purposes, the Secretary of Health and Human Services should amend the approval of Arizona's Health Insurance Flexibility and Accountability waiver to prevent future use of SCHIP funds on children's adults.	Closed - Not Implemented *
3		To ensure that SCHIP funds are spent only for authorized purposes, the Secretary of Health and Human Services should deny any pending or future state proposals to spend SCHIP funds for this purpose.	Closed - Not Implemented *
GAO-02-817	Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns	To meet its fiduciary responsibility of ensuring that section 1115 waivers are budget neutral, the Secretary of Health and Human Services should better ensure that valid methods are used to demonstrate budget neutrality. In addition, the Secretary should consider the impact of the consideration of section 1115 demonstration waiver proposals.	Open *
4		To meet its fiduciary responsibility of ensuring that section 1115 waivers are budget neutral, the Secretary of Health and Human Services should reconsider Utah and Illinois's budget neutrality justifications, in light of GAO's conclusions that certain costs were inappropriate or impermissible and, to the extent appropriate, adjust the limit on the federal government's financial obligation for these waivers.	Closed - Not Implemented *
5		To help ensure that the Florida demonstration will maintain the fiscal integrity of the Medicaid program, the Secretary of HHS should ensure that the Medicaid program in Florida is not used to offset other federal Medicaid funds in the absence of the proposed demonstration is calculated using appropriate methods and accurate data sources, and adjust the approved spending limit appropriately.	Closed - Not Implemented *
GAO-08-87	Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns		
6		To improve the transparency of the process for reviewing and approving demonstration waivers, the Secretary of Health and Human Services should update the agency's written budget neutrality policy to reflect actual criteria and processes used to develop and approve demonstration spending limits, and ensure the policy is readily available to state Medicaid directors and others.	Implemented
7	GAO-13-384 Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lacks Transparency	To improve the transparency of the process for reviewing and approving spending limits for comprehensive section 1115 demonstrations, the Secretary of Health and Human Services should reconsider adjustments and costs used in setting the spending limits of the demonstration and consider the impact of the demonstration on the remaining years of each demonstration.	Open *
8			
GAO-13-553	Indian Health Service: Most American Indians and Alaska Natives Remain Ineligible for Expanded Health Coverage, but Action Needed to Increase Enrollment	To help ensure successful outreach efforts resulting in significant new enrollment, the Secretary of Health and Human Services should develop a plan to educate state Medicaid agencies about when coverage status information may be shared between states and IHS facilities, tribal facilities, and urban Indian health programs (UIIU) facilities and tribes.	Open
9			

1	B Product Number	C Product Title	D Recommendation Text	E Status
1	GAO-14-362	Foster Children: Additional Federal Guidance Could Help States Monitor and Oversight for Children in Foster Care, Medicaid, Child Welfare, and Mental Health Officials Regarding Prescription-Drug Monitoring and Oversight for Children in Foster Care Receiving Psychotropic Medications through MCOs.	To assist states that rely on or are planning to contract with an MCO to administer Medicaid prescription benefits, and to help provide effective oversight of psychotropic medications prescribed to children in foster care, Medicaid, child welfare, and mental health officials regarding prescription-drug monitoring and oversight for children in foster care receiving psychotropic medications through MCOs.	Open
10			The Administrator of CMS should develop a data collection strategy that would require states to report information on the nonfederal share of Medicaid payments, and (2) in the long-term, as part of its short- and long-term possibilities for pursuing the data collection strategy, including (1) in the short-term, as part of its ongoing initiative to annually collect information on the nonfederal share of Medicaid payments from other institutional providers, CMS could collect accurate and complete facility-specific data on the sources of funds used to finance the nonfederal share of the Medicaid payments, and (2) in the long-term, as part of its ongoing initiative to develop a national data system (NDS) for Medicaid payments, CMS could require that MCOs be capable of capturing information on all sources of funds used to finance the nonfederal share of Medicaid payments, and, once the system becomes operational, ensure that states report this information for supplemental Medicaid payments and correct Medicaid payments.	Open *
11	GAO-14-627	Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection [Reissued on March 13, 2015]	To ensure that the federal government's and states' investments in information systems result in outcomes that are effective in supporting Medicaid financing, the Administrator of CMS should require that states report information on the Medicaid program, the Secretary of Health and Human Services should direct the Administrator of CMS to require states to measure quantifiable benefits, such as cost reductions or avoidance, achieved as a result of opening information systems to states, and direct the Administrator of CMS to require that states report information on consistent and repeatable approach and should be reported when requesting approval for matching federal funds to support ongoing operation and maintenance of systems that were implemented to support Medicaid program integrity purposes.	Open *
12	GAO-15-207	Medicaid Information Technology: CMS Supports Use of Program Integrity Systems but Should Require States to Determine Effectiveness	To improve CMS's oversight of Medicaid payments, the Administrator of CMS should develop a policy establishing criteria for when such payments at the provider level are economical and efficient.	Open
13			To improve CMS's oversight of Medicaid payments, the Administrator of CMS should take steps to ensure that states report accurate provider-specific payment data that include accurate unique national provider identifiers (NPI).	Open
14	GAO-15-322	Medicaid: CMS Oversight of Provider Payments Is Hindered by Limited Data and Under Policy	To improve CMS's oversight of Medicaid payments, the Administrator of CMS should, once criteria are developed, develop a process for identifying and reporting provider payments in order to determine whether they are economical and efficient.	Open
15				Open

15	B Product Number	C Product Title	D Recommendation Text	E Status
16	GAO-15-239	Medicaid Demonstrations: Approval Criteria and How States Are to Show How Spending Turns Medicaid Objectives	To improve the transparency and accountability of HHS's section 1115 Medicaid demonstration approval process, and to ensure that federal Medicaid funds for the demonstrations do not duplicate other federal funds, HHS should develop and publish a set of criteria for states to use in assessing whether section 1115 expenditure authorities are likely to promote Medicaid objectives.	Open
17	GAO-16-73	Medicaid and Insurance Exchanges: Additional Federal Controls Needed to Minimize Potential for Gaps and Duplication in Coverage	To improve the transparency and accountability of HHS's section 1115 Medicaid demonstration approval process, and to ensure that federal Medicaid funds for the demonstrations do not duplicate other federal funds, the Secretary of Health and Human Services should ensure the application of these criteria is documented in all HHS's approvals of section 1115 demonstrations. HHS should also ensure that states are not duplicating existing expenditure authorities, to inform internal and external stakeholders, including states, the public, and Congress, of the basis for the agency's determinations that approved expenditure authorities are likely to promote Medicaid objectives.	Open
18	GAO-16-53	Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds	To better minimize the risk of coverage gaps and duplicate coverage for individuals transitioning between Medicaid and the exchange in FTE states, the Administrator of CMS should routinely monitor the timeliness of account transfers from state Medicaid programs to CMS and identify alternative procedures if near real time transfers are not feasible in a state.	Open
19	GAO-16-238	Nonemergency Medical Transportation: Updated Medicaid Guidance Could Help States	To improve the effectiveness of its oversight of eligibility determinations, CMS should develop and publish guidance for states to use in making eligibility determinations to ascertain the accuracy of these determinations and institute corrective action plans where necessary.	Open
20	GAO-16-108	Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments	To increase assurances that states receive an appropriate amount of federal matching funds, the Administrator of CMS should use the information obtained from state and federal eligibility reviews to inform the agency's assessments of state Medicaid programs and ensure that federal expenditures are reported correctly and matched appropriately.	Open *
21	GAO-16-238	Nonemergency Medical Transportation: Updated Medicaid Guidance Could Help States	To ensure states have appropriate and current guidance to assist them in describing and administering Medicaid NEMT, the Secretary of HHS should direct CMS to assess current Medicaid NEMT guidance and update that guidance as needed.	Open
22	GAO-16-108	Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments	To ensure states have appropriate and current guidance to assist them in describing and administering Medicaid NEMT, the Secretary of HHS should direct CMS to assess current Medicaid NEMT guidance and update that guidance as needed.	Open
23	GAO-16-108	Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments	To promote consistency in the distribution of supplemental payments among states and with CMS policy, the Administrator of CMS should issue written guidance clarifying its policy that requires a link between the distribution of supplemental payments and the provision of Medicaid- covered services.	Open *

Product Number	Product Title	Recommendation Text	Status	E
1				
GAO-16-324	Medicaid and CHIP: Increased Funding in U.S. Territories Means Improved Program Integrity Efforts	To ensure the appropriate level of Medicaid program integrity oversight in the territories, the Acting Administrator of CMS should rename CMS's program integrity strategy and develop a cost-effective approach to enhancing Medicaid program integrity in the territories. Such an approach could include, for example, establishing program oversight mechanisms, such as requiring territories to establish a Medicaid Fraud Control Unit or working with them to obtain necessary exemptions or waivers from applicable program oversight requirements. CMS should also continue to monitor and conduct additional program assessments of program integrity as warranted.	Open	
24				
GAO-16-402	Medicaid Program Integrity: Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers	To improve the effectiveness of states' and plans' MHC plan provider screening efforts, the Acting Administrator of CMS should coordinate with other federal agencies, as necessary, to explore the use of an identifier that is relevant for the screening of MHC plan providers and common across databases used to screen MHC plan providers.	Open	
25				
GAO-16-568	Hospital Uncompensated Care: Federal Action Needed to Better Align Payments with Costs	To ensure efficient use of federal resources, the Administrator of CMS should account for Medicaid payments a hospital has received that only a portion of which are used to offset uncompensated care costs for the purposes of making Medicare UC payments to individual hospitals.	Open	
26				
27	Medicaid Personal Care Services: CMS Could Do More to Harmonize Requirements across Programs	To achieve a better understanding of the effect of certain Personal Care services (PCS) services on beneficiaries and a more consistent administration of policies and procedures across PCS programs, the Acting Administrator of CMS should collect and analyze states' required Community First Choice programs on the health and welfare of beneficiaries as well as the state quality measures for the Participant-Directed Option and Community First Choice programs.	Open	
28				
GAO-17-129	Foster Care: HHS Has Taken Steps to Support States' Oversight of Psychotropic Medications, but Additional Assistance Could Further Collaboration	To achieve a better understanding of the effect of certain PCS services on beneficiaries and a more consistent administration of policies and procedures across PCS programs, the Acting Administrator of CMS should collect and analyze states' required Community First Choice programs on the health and welfare of beneficiaries as well as the state quality measures for the Participant-Directed Option and Community First Choice programs.	Open	
29		To help states effectively address ongoing challenges related to ensuring the appropriate use of psychotropic medications for children in foster care, the Secretary of HHS should encourage states to create state child welfare, Medicaid, and other stakeholders to promote collaboration and information sharing within and across states on psychotropic medication oversight.	Open - HHS is the lead on this recommendation	

Product Number	Product Title	C	D	Status	E
1					
GAO-17-173	Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements		The Administrator of CMS should take immediate steps to assess and improve the data available for Medicaid program oversight, including, but not limited to, T-HSIS. Such steps could include (1) refining the overall data priority areas in T-HSIS to better identify those variables that are most critical to program oversight and (2) improving data quality and completeness, including efforts to assess and ensure the quality of fees in T-HSIS data.	Open	
30					
31			To improve oversight of states' payment structures for MLTSS, the Administrator of CMS should require all states to collect and report on progress toward achieving MLTSS program goals, such as whether the program enhances the provision of community-based care.	Open	
GAO-17-145	Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports		To improve oversight of states' payment structures for MLTSS, the Administrator of CMS should provide states with guidance that includes minimum standards for encounter data validation procedures.	Open	
32			To improve oversight of states' payment structures for MLTSS, the Administrator of CMS should establish criteria for what situations would warrant exceptions to the federal standards that the data used to set rates be no older than the three most recent and complete years.	Open	
33			To improve the collection of complete and consistent personal care services data and better ensure CMS can effectively monitor the states' provision of data and personal care services data collected from states through T-HSIS and WBS, CMS should require states to comply with CMS reporting requirements.	Open	
GAO-17-169	Medicaid: CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services		To improve the collection of complete and consistent personal care services data and better ensure CMS can effectively monitor the states' provision of data and personal care services data collected from states through T-HSIS and WBS, CMS should require states to comply with CMS reporting requirements.	Open	
34					
35					
36			To build upon CMS's collaborative audit efforts and help enhance future oversight, CMS should encourage states to participate in collaborative audits, limit states' participation in collaborative audits. Such opportunities could include improving communication with states before, during, and after audits are completed, and ensuring that audits align with states' program integrity needs and the need for oversight of services provided in managed care delivery systems.	Open	
GAO-17-277	Medicaid Program Integrity: CMS Should Build on Current Oversight Efforts by Further Enhancing Collaboration with States		To better support states' efforts to reduce improper payments and improve program integrity, CMS should collaborate with states to develop a systematic approach to collect promising state program integrity practices.	Open	
37					
38			To better support states' efforts to reduce improper payments and communicate effective program integrity practices across the states, CMS should collaborate with states to create and implement a communication strategy for sharing promising program integrity practices with states in an efficient and timely manner.	Open	

Product Number	Product Title	Recommendation Text	Status
1 GAO-17-312 39	Medicaid Demonstrations: Federal Action Needed to Improve Oversight of Spending	To improve consistency in CMS oversight of federal spending under section 1115 demonstrations, the Secretary of Health and Human Services should require the Administrator of CMS to develop and document standard operating procedures for monitoring spending under demonstrations that (1) require setting reporting requirements for states that provide CMS the data elements needed for CMS to assess compliance with the terms of the demonstration; (2) require consistent tracking of the amount of unspent funds under demonstration spending limits.	Open
40		To improve consistency in CMS oversight of federal spending under section 1115 demonstrations, the Secretary of Health and Human Services should require the Administrator of CMS to issue formal guidance on the revised policy neutrality policy, including information on how the policy will be applied.	Implemented
41 GAO-17-632	Medicaid Managed Care: CMS Should Improve Oversight of States' Long-Term Services and Supports Programs	To improve CMS's oversight of states' MLTSS programs, the Administrator of CMS should take steps to identify and obtain key information needed to assess state MLTSS programs, including, at a minimum, obtaining information specific to network adequacy, critical incidents, and appeals and grievances.	Open
42		The Administrator of CMS should conduct fraud risk assessments for Medicare and Medicaid to include respective fraud risk profiles and plans for regularly updating the assessments and profiles.	Open
43 GAO-18-88	Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework	The Administrator of CMS should provide fraud-awareness training relevant to risks facing CMS programs and require new hires to undergo such training and all employees to undergo training on a recurring basis.	Open
44		The Administrator of CMS should, using the results of the fraud risk assessments for Medicare and Medicaid, create, document, implement, and communicate an antifraud strategy that is aligned with and responsive to regularly assessed fraud risks. This strategy should include an approach for identifying and responding to fraud risks.	Open
45		The Administrator of CMS should articulate a specific plan and associated time frames for using T-HSIS data for oversight.	Open
GAO-18-70 46	Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight	The Administrator of CMS, in partnership with the states, should take additional steps to expedite the use of T-HSIS data for program oversight. Specifically, CMS should (1) complete information from all states on unreported T-HSIS data elements and their plans to report applicable data elements; (2) identify and share information across states on known T-HSIS data limitations to improve data comparability; and (3) improve the consistency and quality of T-HSIS data by improving the completeness, comparability, and utility of T-HSIS data.	Open

1	B Product Number	C Product Title	D Recommendation Text	E Status
47	GAO-18-103	Medicaid: CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services	The Administrator of CMS should ensure that all types of Medicaid HCBS contracts are subject to the same oversight and that CMS requires states to conduct needs assessments that are used to determine eligibility for HCBS and to develop HCBS plans of service. These requirements should address both service providers and managed care plans conducting such assessments.	Open
48			The Administrator of CMS should ensure that all states submit annual reports for HCBS waivers on time as required.	Open
49	GAO-18-179	Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare Is Needed	The Administrator of CMS should establish standard Medicaid reporting requirements for all states to annually report key information on critical incidents, considering, at a minimum, the type of critical incidents involving Medicaid beneficiaries, and the type of residential facilities, including assisted living facilities, where critical incidents occurred.	Open
50			The Administrator of CMS should provide guidance and clarify requirements regarding the monitoring and reporting of deficiencies that states using home and community-based services (HCBS) waivers are required to report on their annual reports.	Open
51			The Administrator of CMS should establish and implement a policy for publicly releasing findings from federal evaluations of demonstrations, including findings on implementation, and final reports; and this policy should include standards for timely release.	Open
52	GAO-18-220	Medicaid Demonstrations: Evaluations Yielded Limited Information Regarding Need for Changes to Federal Policies and Procedures	The Administrator of CMS should establish written procedures for implementing the agency's policy that requires all states to submit a final evaluation report after the end of each demonstration cycle, regardless of operational status.	Open
53			The Administrator of CMS should issue written criteria for when CMS will publicly release findings from federal evaluations of demonstrations, including defining conditions, such as what it means for a demonstration to be longstanding or noncomplex, as applicable.	Open
54	GAO-18-291	Medicaid: CMS Should Take Steps to Mitigate Program Risks in Managed Care	The Administrator of CMS should consider and take steps to mitigate the program risks that are not measured in the PERM, such as overpayments and unallowable costs, such an effort could include actions such as revising the PERM methodology or focusing additional audit resources on managed care.	Open
55			The Administrator of CMS should eliminate procedures to collaborative audits of managed care conducted by state contractors and states by ensuring that managed care audits are conducted regardless of which entity—the state or the managed care organization—recoups any identified overpayments.	Open
56	GAO-18-528	Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks	The Administrator of CMS should expedite the planned efforts to communicate guidance, such as its compendium on Medicaid managed care program integrity, to state stakeholders related to Medicaid managed care program integrity.	Open

ADDENDUM A

B		C	D	E
Product Number	Product Title	Recommendation Text	Status	
1		The Administrator of CMS should require states to report and document the amount of MCO overpayments to providers and how they are accounted for in their operations reports.	Open	
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Note: An asterisk (*) next to the status indicates that CMS did not concur with the recommendation.

Total 56
Open 50
Closed - Not Implemented 4
Closed - Implemented 2